

MEDICAID MANAGED CARE MEMBER HANDBOOK

This handbook will tell you how to use MetroPlus Health Plan

Put this handbook where you can find it when you need it.

HERES WHERE TO FIND INFORMATION YOU WANT

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Welcome to MetroPlus Health Plan's Medicaid Managed Care Program

We are glad that you chose MetroPlus Health Plan. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, just call us at 1-800-303-9626.

HOW TO USE THIS HANDBOOK

- This handbook is your guide to health services. It tells you the steps to take to make the Plan work for you.

The first several parts of this handbook tells you what you need to know right away. The rest of the handbook can wait until you need it. When you have a question, check this handbook or call MetroPlus Member Services toll-free at **1-800-303-9626 (TDD: 1-800-881-2812)**. You can also call the Medicaid CHOICE HelpLine at **1-800-505-5678**. Members in New York City who get Supplemental Security Income (SSI) or who are certified blind or disabled can call New York Medicaid CHOICE at 1-800-774-4241.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:

Monday through Saturday 8AM - 8PM

If you are hearing impaired (have a hearing problem) and can get to a TDD/TTY machine please call us toll free at: **1-800-881-2812** . If you have a vision problem and would like to use a Braille handbook or a recorded (audio

tape) handbook, call Member Services.

If you need medical help after business hours, on weekends or holidays, call the MetroPlus 24-Hour Health Care Hotline toll-free at **1-800-442-2560**.

- You can call to get help **anytime you have a question**. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.
- **If you are or become pregnant**, your child will become part of MetroPlus on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.
- We offer **free orientation sessions**. These are meetings for new members where a Member Services representative explains our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.



- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.

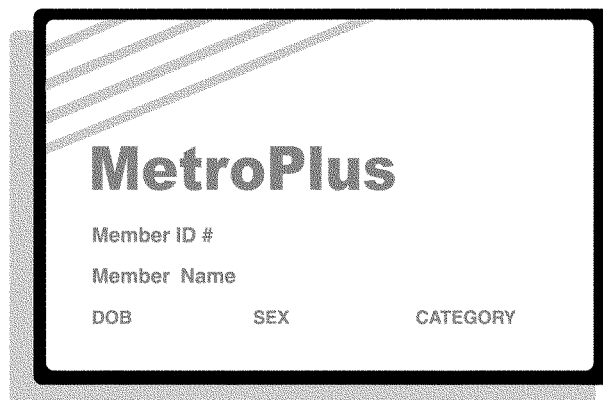
- **For people with disabilities:** If you use a wheelchair, or are blind or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices.

Also, we have services like:

- TDD/TTY machine (Our TDD/TTY phone number is 1-800-881-2812)
- Information in Large Print
- Case Management
- Help in Making or Getting to Appointments
- Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter and a MetroPlus ID Card. These will be mailed within 14 days after your membership effective date. Your card has your PCP's name and phone number on it. It will also have your



client identification number (CIN). If information on the card is wrong, call Member Services right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that MetroPlus does not cover. These services include pharmacy benefits.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

- No doubt you have seen or heard about the changes in health care. Many people now get their health benefits through managed care. Many counties in New York State, including New York City, offer their clients a choice of managed care health plans. In some counties, Medicaid clients must join a health care plan. This is called a **mandatory managed care program**. Other counties allow their clients to choose whether they want to join managed care. This is called a **voluntary Medicaid managed care program**. Both programs, though, allow for some people to keep getting care through regular Medicaid.

- MetroPlus members, who live in New York County, are in a mandatory Medicaid managed care program.

MetroPlus has a contract with the New York City Department of Health and Mental Hygiene to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network**. You'll find a list in our

Provider Directory. If you don't have a Provider Directory, call 1-800-303-9626 to get a copy.

- When you join MetroPlus one of our providers will take care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you everyday, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See pages 8-9 for details.

PART I FIRST THINGS YOU SHOULD KNOW HOW TO CHOOSE YOUR PCP

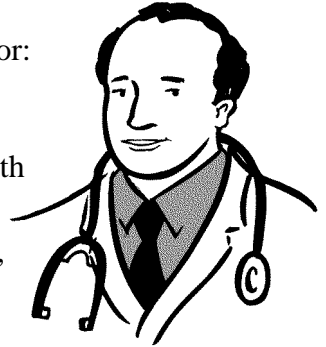
- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Each family member can have a different PCP or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.

- With this Handbook, you should have a Provider Directory. This is a list of all the doctors, clinics, hospitals, labs, and others who work with MetroPlus. It lists the address,

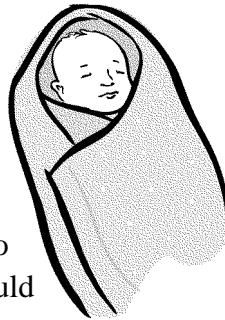
phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

- who you have seen before,
- who understands your health problems,
- who is taking new patients,
- who can serve you in your language, or
- who is easy to get to.



- Women can also choose one of our OB/GYN doctors to deal with women's health issues.



Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine check ups (twice a year), follow-up care if there is a problem, and regular care during pregnancy.

- We also contract with several FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some clients want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose one of our providers. Or you can sign up with a PCP at one of the FQHCs that we work with. You will find a listing of FQHC providers on page 11 of our Provider Directory or call Member Services at 1-800-303-9626 for help.

- In almost all cases, your doctors will be MetroPlus providers. In some cases you can continue to see another doctor that you had before you joined MetroPlus, even if he or she does not work with our plan. You can continue to see your doctor if:

- You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery and follow up care.
- At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

In both cases, however, your doctor must agree to work with MetroPlus.

- If you have a long-lasting illness, like HIV/AIDS or other long term health problems, you may be able to **choose a specialist to act as your PCP**. You or your provider can call Member Services with this request which will be reviewed and approved on a case-by-case basis.

- If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change at least twice in a 12 month period without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which, your PCP has referred you.

- If your **provider leaves MetroPlus**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60

days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days from the date your provider leaves MetroPlus. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-303-9626.



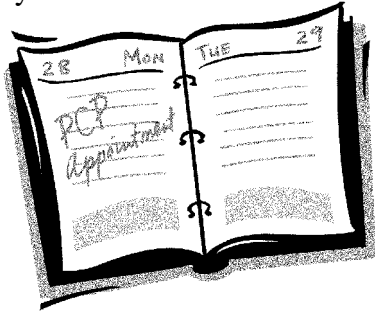
HOW TO GET PRIMARY (REGULAR) CARE

- Primary care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to a hospital or specialist when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be **medically necessary**. The services you get must be needed:

1. to prevent, or diagnose and correct what could cause more suffering, or

2. to deal with a danger to your life, or
3. to deal with a problem that could cause illness, or
4. to deal with something that could limit your normal activities.



- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. If you can, prepare for your first appointment. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask. In most cases, your first visit should be within three months of your joining the plan.

- If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**

- adult baseline and routine physicals: within 12 weeks
- urgent care: within 24 hours

- non-urgent sick visits: within 3 days
- routine, preventive care: within 4 weeks
- first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- first newborn visit: within 2 weeks of hospital discharge
- first family planning visit: within 2 weeks
- follow-up visit after mental health/substance abuse ER or inpatient visit: 5 days
- non-urgent mental health or substance abuse visit: 2 weeks.

HOW TO GET SPECIALTY CARE AND REFERRALS

- If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask MetroPlus to approve *before* you can get them. Your PCP will be able to tell you what they are.

- 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 23 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.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
 - your specialist to act as your PCP; or
 - a referral to a specialty care center that deals with the treatment of your problem.You can also call Member Services for help in getting access to a specialty care center.

GET THESE SERVICES FROM METROPLUS WITHOUT A REFERRAL

Women's Services

- You do not need a referral from your PCP to see one of our providers if:
 - you are pregnant,
 - you need OB/GYN services,
 - you need family planning services,
 - you want to see a mid-wife,
 - you need a breast or pelvic exam.



Family Planning

- You can get the following family planning services: advice for birth control, pregnancy tests, sterilization, or a medically necessary abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.
- You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your MetroPlus ID card to see one of MetroPlus Health Plan's family planning providers. Check the plan's Provider

Directory or call Member Services for help in finding a provider. Or, you can use your Medicaid card if you want to go to a doctor or clinic outside MetroPlus. Ask your PCP or call Member Services at 1-800-303-9626 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (**1-800-522-5006**) for the names of family planning providers near you.

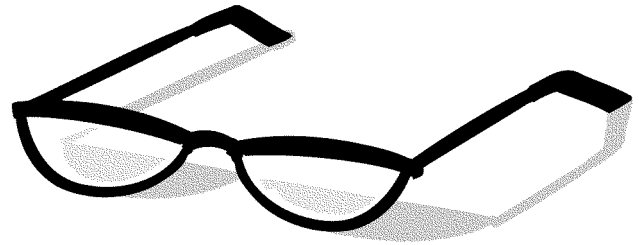
HIV Counseling and Testing

- You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with one of our family planning providers.
- Or, if you'd rather not see one of MetroPlus Health Plan's providers, you can use your Medicaid card to see a family planning provider outside the Plan. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at **1-800-303-9626**.
- If you want HIV testing and counseling but *not as part of a family planning service*, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the NYS HIV Counseling Hotline at **1-800-872-2777** or **1-800-541-AIDS**.
- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

Eye Care

The covered benefits include the needed services of an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more

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



Mental Health/Chemical Dependence (including alcohol and substance abuse)

You may go for one (1) mental health assessment without a referral in any 12 month period. You must use a MetroPlus provider, but you do not need an OK from your PCP.

You may also go for one (1) chemical dependence assessment for all inpatient detoxification, inpatient rehabilitation, or outpatient detoxification services, without a referral in any 12 month period. You must use a Plan provider, but you do not need an OK from your PCP. If you need more visits, your PCP will help you get a referral.

If you want a chemical dependence assessment for any alcohol and/or substance abuse outpatient treatment services, except outpatient detoxification services, you must use your Medicaid Benefit card to go to any provider that takes Medicaid.

EMERGENCIES

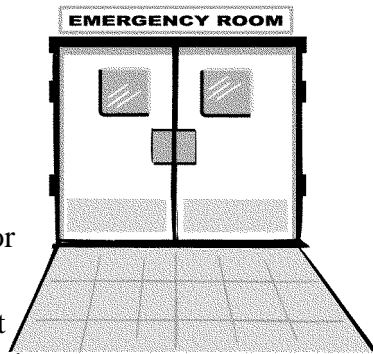
You are always covered for emergencies. An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain,
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting



Examples of things that are usually NOT emergencies: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

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

- **Call 911 or go to the emergency room.** You do not need your plan's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

- **If you're not sure, call your PCP or MetroPlus 1-800-303-9626**

After hours call our 24-Hour Health Care Hotline at 1-800-442-2560.

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

- tell you what to do at home,
- tell you to come to the PCP's office, or
- tell you to go to the nearest emergency room.

- If you are **out of the area** when you have an emergency:

- Go to the nearest emergency room.
- Call MetroPlus as soon as you can (within one business day if you can).

Remember

You do not need prior approval for emergency services.

Use the emergency room **only** if you have an **Emergency**.

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

If you have questions, call your PCP during regular business hours or MetroPlus at 1-800-303-9626. After hours call our 24-Hour Health Care Hotline at 1-800-442-2560.

URGENT CARE

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

- a child with an earache who wakes up in the middle of the night and won't stop crying, or
- a sprained ankle, or
- a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Call your PCP during regular business hours. At other times, call the 24 Hour Health Care Hotline at 1-800-442-2560. Tell the person who answers what is happening. They will tell you what to do.

WE WANT TO KEEP YOU HEALTHY

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

- Classes for you and your family
- Stop-smoking classes
- Pre-natal care and nutrition
- Grief/loss support
- Breast feeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and DiabetesPlus program for members with serious diabetes
- AsthmaPlus program for members with bad asthma
- MetroMom program for pregnant members

AsthmaPlus Program



MetroMom
The key to healthy babies 

Call Member Services at 1-800-303-9626 (TDD/TTY: 1-800-881-2812) to find out more about these programs.

PART II — Your Benefits and Plan Procedures

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

BENEFITS COVERED BY METROPLUS

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. MetroPlus will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service.

SERVICES COVERED BY METROPLUS

You must get these services from the providers who are in MetroPlus, unless it is an emergency or we have authorized services from a provider who is not in our plan.

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye and hearing exams

Preventive Care

- well baby care
- well child care
 - regular check-ups
 - shots for children from birth through childhood



Maternity Care

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

Home Health Care (must be medically needed and arranged by MetroPlus)

- at least 2 visits to high-risk infants (newborns)
- visit to women who stay in the hospital less than 48 hours after birth
- visit to women who stay in the hospital less than 96 hours after a Cesarean birth
- other home health care visits as needed and ordered by your PCP/specialist

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- eye exams, generally every two years, unless medically needed more often
- glasses (new pair of Medicaid approved frames every two years, or more often if medically needed)

- low vision exam and vision aids ordered by your doctor
- referral to a specialist for eye diseases or defects

Hospital Care

- inpatient care
- outpatient care
- lab, X-ray, other tests



Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services**.
- For more about emergency services, see page 9.

Mental Health/Chemical Dependence (Including Alcohol and Substance Abuse)

- All inpatient mental health and chemical dependence services (including alcohol and substance abuse)
- Most outpatient mental health services (contact plan for specifics)
- Medicaid recipients who receive SSI or are certified blind or disabled can get mental health and chemical dependence (including alcohol and substance abuse) services from any Medicaid provider by using their Medicaid Benefit Card. Detoxification services, however, are covered by the plan as a benefit.

Specialty Care

Includes the services of other practitioners, including

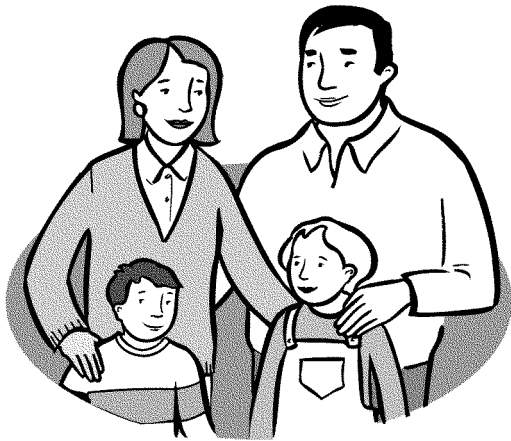
- Occupational, physical and speech therapists and audiologists
- Midwives

Residential Health Care Facility Care (Nursing Home)

- When ordered by your physician and authorized by MetroPlus
- When the stay in the nursing home is not determined permanent by your LDSS
- Covered nursing home services include medical supervision, 24-hour nursing care, assistance with activities of daily living, physical therapy, occupational therapy, and speech-language pathology.

Other Covered Services

- Transportation including emergency ambulance service and non-emergency transport as needed to obtain health care covered by Medicaid. The non-emergency transportation may be by bus or subway, or if your medical condition requires it, by ambulette, taxi or other livery service. When the member is a child, transportation for the parent or guardian who accompanies the child is also covered. When necessary, an attendant for an adult member will be covered.
- Durable Medical Equipment (DME)/Hearing Aids/Prosthetics/Orthotics
- Court Ordered Services
- Comprehensive Medicaid Case Management (“CMCM” program)
- Social Support Services (help in getting community services)
- FQHC or similar services
- Family planning
- Podiatry for children and persons with special problems (i.e., diabetes, etc.)



BENEFITS YOU CAN GET FROM METROPLUS OR WITH YOUR MEDICAID CARD

For some services, you can choose where to get care. You can use your MetroPlus ID Card.

You can also go to providers who will take your Medicaid Benefit card. *You do not need a referral from your PCP to get these services.* Call Member Services if you have questions at 1-800-303-9626.

Family Planning

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

HIV Testing and Counseling

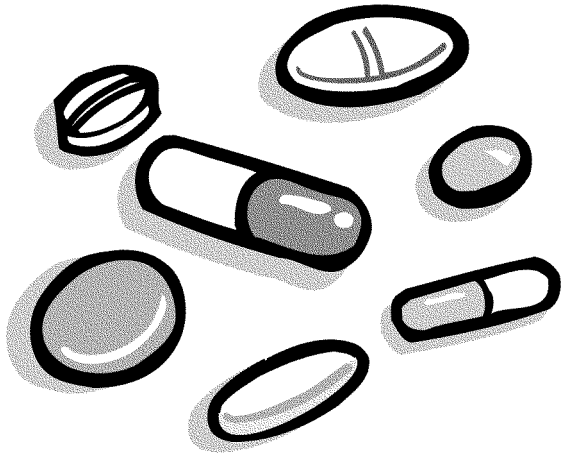
You can get these services from MetroPlus doctors if you talk to your PCP first. When you get these services as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit. You can also go to anonymous counseling and testing clinics offered by the state and local health departments. To get more information about these sites, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.

TB Diagnosis and Treatment

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

BENEFITS USING YOUR MEDICAID CARD ONLY

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



Pharmacy

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

Dental Services

You can go to any dentist who takes Medicaid.

Mental Health

- Intensive psychiatric rehab treatment
- Day treatment
- Intensive case management
- Partial hospital care
- Rehab services to those in community homes or in family-based treatment

- Clinic services for children with a diagnosis of Serious Emotional Disturbance (SED), at mental health clinics certified by the State Office of Mental Health
- Continuing day treatment
- All covered mental health services for people who receive SSI or who are certified blind or disabled are available by using the Medicaid benefit card.

Mental Retardation and Developmental Disabilities

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

Alcohol and Substance Abuse Services

- Methadone treatment
- Out-patient substance abuse treatment
- Out-patient alcohol rehab
- Out-patient alcohol clinic services
- Out-patient chemical dependence for youth programs
- Chemical dependence (including alcohol and substance abuse) services ordered by the LDSS
- All covered alcohol and substance abuse services (except detox) are available for people who receive SSI or who are certified blind or disabled by using their Medicaid benefit card. Detox services are available using your MetroPlus ID card.

Other Medicaid Services

- Personal care services
- Preschool and school services programs (early intervention)
- Early start programs
- Comprehensive Medicaid Case Management program
- TB therapy/DOT
- Adult day treatment for persons with HIV
- Long-term home health care
- Hospice care

SERVICES NOT COVERED

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

- Cosmetic surgery if not medically needed
- Routine foot care (for those 21 years and older)
- Personal and comfort items
- Infertility treatments
- Services from a provider who is not part of MetroPlus (unless MetroPlus authorizes these services), except in emergency situations when no authorization is required
- Services for which you need a referral (approval) in advance and you did not get it.

You may have to pay for any service that your PCP does not approve. Also, if before you get a service, you agree to be a “private pay patient” you will have to pay for the service. This includes:

- Non-covered services (listed above),
- Unauthorized services,
- Services provided by providers not part of MetroPlus

If you have any questions, call Member Services at 1-800-303-9626.

HOW OUR PROVIDERS ARE PAID

MetroPlus pays our providers in one or more of the following ways.

- Our PCPs who work in a clinic or health center probably get a **salary**. The number of patients they see does not affect this.
- Our PCPs who work in their own offices may get a set fee each month for each patient for whom they are the PCP. The fee stays the same whether the patient needs one visit or many or even none at all. This is called **capitation**.
- Sometimes providers get a set fee for each person on their patient list, but some money, (maybe 10%) can be held back for an **incentive** fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by **fee-for-service**. This means they get a Plan-agreed-upon fee for each service they provide.

Service Authorization, Concurrent Review and Actions

Prior Authorization:

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

Your PCP can approve referrals to **Participating Providers** for:

- Specialty care
- Radiology (X-ray, MRI, CT, etc.)
- Laboratory services
- Hearing and vision checks
- Transportation (non-public)
- Referral for eye examinations
- Mental Health or Substance Abuse outpatient services

You or your PCP must get an OK from MetroPlus before you:

- Are referred to a provider who is not in the MetroPlus network, unless it is an emergency
- Are given a standing referral to a specialist
- Are admitted to a hospital, unless it is an emergency or to deliver a baby
- Are assigned a private duty nurse in the hospital
- Are admitted to a skilled nursing facility
- Receive home care services
- Obtain durable medical equipment (DME) including Orthotics and Prosthetics
- Receive Lupron, Botox or Synagis injections in your doctor's office

When you or your PCP requests an OK in advance (prior authorization) from MetroPlus, we will check the treatment plan against medical standards. We will make a decision and tell you (or a person you ask us to speak with for you) and your provider after we have the information needed to make a decision. We will give this information by phone and in writing.

Asking for approval of a treatment or service is called a **service authorization request**. You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This is called **concurrent review**.

To get approval for these treatments or services you need to contact our **Utilization Review (UR) Department 1-800-303-9629 or by Fax 212-908-8521**. Utilization review is what we do to decide whether treatment is medically necessary and will be approved or paid for by MetroPlus Health Plan. Doctors and nurses make the decisions. They do this by checking your treatment plan against medically acceptable standards.

Our UR staff can be reached from 8:30 a.m. to 5:00 p.m. Monday through Friday by calling **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 the information we will need to respond to your question or request. We have a 24-Hour Health Care Hotline number **1-800-442-2560** to use if you need assistance with a medical problem. UR staff will respond to your message on the next business day.

You or your doctor may also submit a service authorization request in writing by sending it to:

MetroPlus Health Plan
160 Water Street, 12th Floor
New York, NY 10038
Attention: Prior Authorization

What happens after we get your service authorization request:

The health plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

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

specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for prior authorization requests:

- Standard review: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests:

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from

us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.

- Fast track review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

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

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

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

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

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions About Your Care:

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that we later denied, unless you signed a paper with your provider saying you would pay for the care if the plan did not.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-303-9626 to find out how you can help.



INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at 1-800-303-9626

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

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

KEEP US INFORMED

Call Member Services 1-800-303-9626 whenever these changes happen in your life:

- You change your name, address or telephone number.
- You have a change in Medicaid eligibility.
- You are pregnant.
- You give birth.

If you no longer get Medicaid, check with your local HRA office. You **may** be able to enroll your children in Child Health Plus, even if you lose Medicaid coverage.



DISENROLLMENT AND TRANSFERS

1. If YOU Want to Leave The Plan

When your county requires you to join a Medicaid health plan (a mandatory county):

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

Some examples of good cause include:

- We cannot provide a suitable PCP for you within 30 minutes or 30 miles from your home.
- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- You are or become exempt or excluded from managed care.
- We do not offer a Medicaid managed care service that you can get from another health plan in your area.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

When your county lets you decide to join a Medicaid health plan or not (a voluntary county):

You can ask to leave the plan at any time for any reason. To disenroll or change plans, just call the Managed Care staff at your local Social Services Department. In New York City call New York Medicaid CHOICE at 1-800-505-5678, to change health plans. The New York Medicaid CHOICE counselors can help you change health plans or disenroll. Members with SSI or who are blind or disabled can call New York Medicaid CHOICE at 1-800-774-4241. It will take between two and six weeks to process, depending on when your request is received. You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Social Services Department or New York Medicaid CHOICE. If you have to be in managed care, you will have to choose another health care plan. Call the managed care unit of your local Social Services Department or New York Medicaid CHOICE to get a transfer or disenrollment packet. Be sure to let them know you are disenrolling from MetroPlus and if you want to re-enroll in a new plan. You will get a notice that the change will take place by a certain date. In most cases, we will provide the care you need until then.

2. You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave MetroPlus if you or the child:
 - Moves out of the County or service area,
 - Changes to another managed care plan,

- Joins an HMO or other insurance plan through work,
 - Joins a long-term Home Health Care Program,
 - Goes to prison, or
 - Becomes a permanent resident of a nursing home.
- Your child may have to leave MetroPlus if he or she:
 - Joins a Physically Handicapped Children's Program, or
 - Is placed in foster care voluntarily by parent/guardian or by a decision of the local Social Services Commissioner
- In some cases, you may be **guaranteed coverage** by MetroPlus. That means we will not drop you as a member during the first six months of your enrollment in our plan — even if you are no longer eligible for Medicaid and your Medicaid case is closed. The reasons for losing eligibility must not be related to death, moving out of state, or incarceration. During this time you can get the services that MetroPlus covers. You can also get pharmacy and family planning care using your Medicaid card. Guaranteed coverage does not apply if you choose to leave MetroPlus.

If there is a change in insurance for you or your children and you no longer get Medicaid, check with your local Department of Social Services. You **may** be able to enroll your children in Child Health Plus, even if you lose Medicaid.

3. We Can Ask You to Leave MetroPlus Health Plan

You can also lose your MetroPlus membership, if you often:

- refuse to work with your PCP in regard to your care,
- don't keep appointments,
- go to the emergency room for non-emergency care,
- don't follow MetroPlus Health Plan's rules,
- do not fill out forms honestly or do not give true information (commit fraud),
- cause abuse or harm to plan members, providers or staff, or
- act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

Action Appeals

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

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

Your provider can ask for reconsideration:

If we made a decision 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 (30) 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 your original denial was because we said the service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

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

- 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 or your fair hearing results in another denial you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

EXTERNAL APPEALS

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.

You may also ask for a fair hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the one that counts.

FAIR HEARINGS

In some cases you may ask for a fair hearing from New York State.

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving MetroPlus.
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and appeal with MetroPlus. If MetroPlus agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you

choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

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

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet,
www.otda.state.ny.us/oah/forms.asp
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201

Remember, you can complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint Process

Complaints:

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

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

You also have the right to contact the New York State Department of Health about your complaint at 1-800-205-8125 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 - 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.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of MetroPlus Health Plan you

have a right to:

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

Your Responsibilities

As a member of MetroPlus Health Plan, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

Advance Directives

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can

help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy — With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR — You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

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

IMPORTANT TELEPHONE NUMBERS

Your PCP

THE PLAN

Member Services1-800-303-9626

Member Services TTY/TDD1-800-881-2812

Other Units (e.g., Nurse Hotline, Utilization Review, etc.)

Your nearest Emergency Room

NYS Health Dept. (Complaints)1-800-206-8125

..... County Department of Social Services

For plans in New York City:

New York Medicaid CHOICE1-800-505-5678

Local Pharmacy

Other Health Care Providers:

_____	_____
_____	_____
_____	_____

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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