YOUR GUIDE TO METROPLUS GOLD CARE 2017-2018.

OUR HEALTH PLAN FOR NEW YORK CITY DAY CARE WORKERS
Welcome to MetroPlus GoldCare

MetroPlus Health Plan, a subsidiary of NYC Health + Hospitals, is a health maintenance organization certified under Section 4403-a of the Public Health Law. This handbook describes the comprehensive benefits you receive as a MetroPlus GoldCare member. This handbook is an important supplement to the MetroPlus GoldCare Certificate of Coverage. Please take the time to read them carefully.

We offer our members many extras to help make getting health care easier and more convenient, including online doctor appointments through Zocdoc, an expanded urgent care network and an enhanced member website that puts you in charge.

For more information on MetroPlus GoldCare, please contact the benefits office where you work, call MetroPlus GoldCare Member Services, Monday through Saturday, 8 AM – 8 PM, 877-475-3795, TTY 711 or go to www.metroplus.org.

Sincerely,

Arnold Saperstein, M.D.
President and CEO
NO DEDUCTIBLE! METROPLUS GOLDCARE GIVES YOU THE BENEFITS YOU WANT. MEMBERS GET:

- Physical examinations
- Visits with the in-network doctor you choose at a health care site convenient to you
- Private doctors’ offices
- Maternity care including routine prenatal care, delivery, and newborn care
- Well baby care including immunizations
- Medically necessary hospital care including room and board, intensive care, physician, and surgical services
- Lab tests and X-rays
- Mental health services
- Special health education and care programs, and lots more
- Value Added Services! Includes member portal

For a full list of benefits, refer to your Certificate of Coverage.
ZOCDOC™ APPOINTMENTS
Now, MetroPlus GoldCare members can make and change their appointments online with any of our Zocdoc-participating providers. Zocdoc was created to solve patient problems, beginning with online appointment-booking. With Zocdoc, you can see doctors’ open appointment times and book instantly online, make informed choices with verified reviews, and stay on top of important checkups with tailored reminders. And those pesky waiting room forms? Fill them out online, just once, and keep them forever.

URGENT CARE CENTERS
MetroPlus members can access an increasing number of Urgent Care Centers throughout the five boroughs to help with a sudden illness, an injury, or a condition that needs care right away, but is not so serious as to require an Emergency Room visit. For a complete list of Urgent Care Centers that accept MetroPlus, go to the “find a doctor” page under the Member Services tab on our website.*

MEMBER WEBSITE
Do more with your membership online! Our Member Website lets you access your account (including member profiles for multiple plans), view and print your member ID card, request a provider change, view your claims/medical appointments history, and much more! Go to metroplus.org and click on “Member Login,” then click on “Members.” Enter your name and password. No user name? Click on “Register for Account.”

*You should always try to obtain urgently needed care from in-network providers and locations. We do not cover Urgent Care from non-participating Urgent Care centers or Physicians.

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MetroPlus Philosophy

MetroPlus' mission is to provide our members with access to quality, cost-effective health care. MetroPlus believes in preventive health care, including immunizations and check-ups, health education and care management. We encourage members and their PCPs to build relationships, which promote personalized health care. MetroPlus GoldCare Member Services is available to help you understand your benefits and access the care you need to stay healthy. We are also committed to confidentiality regarding your medical records.

MetroPlus Terms

Here are some definitions of terms you will need to know. They are used frequently throughout this handbook.

NYC Health + Hospitals provides medical and mental health services to New York City residents. MetroPlus is subsidiary of NYC Health + Hospitals.

Participating Provider means a PCP, specialist, health care facility or other provider that has an agreement with MetroPlus to provide health care services to MetroPlus members.

PCP The Primary Care Provider or primary care team is the physician or nurse practitioner you select to provide your care from a list of approved, participating providers. The PCP takes care of the member’s basic health care needs and refers the member to other providers when necessary.

Medically Necessary Care (Medical Necessity) means health care and services that are necessary to prevent, diagnose, manage or treat 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.

Members Who Do Not Speak English or Require TTY Access

MetroPlus has Member Service Representatives who can help you in many languages on the phone and in person at NYC Health + Hospitals facilities. If necessary, MetroPlus will arrange for interpreter services. Many Participating Providers have staff who speak languages other than English.

If you are hearing-impaired and have access to a TTY machine, please call 711.
Accessing Care

CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

When you become a MetroPlus GoldCare member, we ask you to make several important decisions. First, we ask you and each adult dependent to select a PCP, and for you to select a PCP for each covered dependent from our extensive list of Participating Providers. If a selected PCP practices at more than one site, please pick one site where you or your dependent will regularly go for care. For convenience, you or your dependent may select a PCP near your home or workplace or other convenient location. A female member can choose a MetroPlus OB/GYN as her PCP. If you would like assistance in making your selections, just call 877-475-3795 or TTY 711 and a knowledgeable MetroPlus GoldCare Member Services Representative will be happy to help you.

If your PCP is a MetroPlus PCP, you can continue to see him or her. If you don't have a PCP, you can select one by going to the “Find a Primary Care Provider” tab on the MetroPlus website, www.metroplus.org. On the site, you can search for a PCP who speaks your language, is associated with a particular hospital/facility, has an office in or near a particular zip code that is convenient to you and that is wheelchair accessible. You can find a PCP by looking in the MetroPlus Provider Directory. The Provider Directory indicates PCPs that are not accepting new patients. After you select a PCP, call and make sure that the PCP is taking new patients.

YOUR PCP

MetroPlus makes it easy to obtain most of the health care that you need through your Primary Care Provider (PCP). Whenever you need routine or preventive medical care, you should see you PCP. Only your PCP has the responsibility, with your assistance, for the coordination of your medical care.

Your PCP will provide basic and preventive care, such as checkups and screening tests, help you find Participating Providers who are specialists, if medically necessary, and arrange a hospital admission and other special services.

CHANGING YOUR PCP OR HEALTH CARE SITE

It is extremely important to MetroPlus that you are happy with your PCP and health care site. If you wish to change either one, you may do so easily. Simply call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711. To get a list of MetroPlus PCPs, simply call MetroPlus GoldCare Member Services or visit www.metroplus.org.

HOW TO OBTAIN ROUTINE CARE

Routine care includes exams, regular check-ups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed.

You and your PCP should work together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or on weekends, leave a message and include the phone numbers where you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how MetroPlus works.

Your care must be “medically necessary.” Medically Necessary Care means health care and services that are necessary to prevent, diagnose, manage or treat 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.

SCHEDULING APPOINTMENTS

Your PCP will take care of most of your health care needs – but you must have an appointment to see your PCP. As soon as you choose a PCP, call to make a first appointment. Be prepared to give your name and MetroPlus GoldCare ID Number. Your PCP will need to know your medical history. Prepare for your first appointment. Make a list of your medical background, any problems you have now and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining MetroPlus GoldCare. Remember to bring your MetroPlus GoldCare ID with you to all appointments.

If you need care before your first appointment, call your PCP’s office to explain the problem. Your PCP will give you an earlier appointment. You should still keep the “first” appointment. Use the following list as a guide for our limits on how long you may have to wait for an appointment:

- Your first appointment and routine physicals: within 12 weeks
- Urgent care: within 24 hours
- Non-urgent sick visits: within 3 days
- Routine, preventive care: within 4 weeks
- Non-urgent behavioral health visit: 2 weeks
- First pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd trimester, 1 week during 3rd trimester)
- First family planning visit: within 2 weeks
- Follow-up after a behavioral health Emergency Room or inpatient visit: 5 days

If you cannot keep or need to change an appointment, call your PCP’s office as soon as possible, preferably 24 hours in advance. By doing so, you will allow another MetroPlus member to use the appointment time.
YOUR BASELINE PHYSICAL EXAMINATION

MetroPlus recommends having a comprehensive physical exam, because it is the starting point for your PCP to monitor your health. The baseline examination is an important part of MetroPlus' philosophy of "Preventive Medicine." Once your PCP gathers essential health information about you and your family, he or she will be able to suggest a schedule of follow-up visits as well as immunizations to help you maintain good health.

On your first visit to your PCP, you may be asked to sign a consent form to obtain medical records from your other health care providers. This is routine and will assist your MetroPlus provider in giving you the best care.

Important Note: If a medical problem arises before your initial check-up, please schedule an earlier appointment.

REFERRALS TO A SPECIALIST

If you need care that your PCP cannot provide, your PCP will refer you to a specialist who can. There are some treatments and services that your PCP must ask MetroPlus to authorize before you can get them. It is very important to us that you are happy with your specialist. If you think the specialist does not meet your needs, call or talk to your PCP. You can also call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711 for assistance.

SELF-REFERRAL FOR OB/GYN SERVICES

You do not need a referral from your PCP to make an appointment directly with a Participating OB/GYN provider. Your OB/GYN provider may be an obstetrician, gynecologist, nurse practitioner or licensed midwife. You can choose a Participating OB/GYN as your PCP.

CHOOSING A SPECIALIST FOR A LIFE-THREATENING OR DEGENERATIVE AND DISABLING CONDITION

If you have a disease or condition that is life-threatening or degenerative and disabling, and you require ongoing specialized medical care, you are entitled to have a specialist with expertise in your disease or condition provide or coordinate all of your medical care. You are also entitled to care from a specialty care center accredited or designated as having special expertise in treating your disease or condition. To arrange for these services, ask your PCP or call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711.

OUT-OF-NETWORK REFERRALS

Your PCP must get an authorization from MetroPlus for a referral to a non-Participating Provider, unless it is an emergency. A referral to a non-Participating Provider will be provided only if the services you require are not available from a Participating Provider. MetroPlus prior authorization is required for any referral to a non-Participating Provider. If MetroPlus authorizes the referral to a provider outside our network, you are not responsible for any of the costs other than required copayments.

If MetroPlus determines that care can be provided by a Participating Provider, the request for referral for out-of-network services will not be approved (refer to the Utilization Review section of this manual).

Transitional Out-of-Network Care

WHEN YOU JOIN METROPLUS

If you have a disease or condition that is life-threatening or degenerative and disabling, and you require ongoing specialized medical care, you may be able to continue receiving care from that provider for a transitional period of up to 60 days. If you are in the second trimester of pregnancy and are receiving care from an OB/GYN who is not in our network, you may be able to continue care with that OB/GYN throughout your pregnancy, delivery, and postpartum care related to the delivery. Your provider must agree to the following conditions:

1. Accept reimbursement from the MCO at established rates;
2. Adhere to plan's quality assurance requirements;
3. Provide plan with necessary medical information related to this care;
4. Adhere to the plan's policies and procedures.

IF YOUR PROVIDER LEAVES THE METROPLUS NETWORK

We will tell you within 15 days after we learn about your provider's departure from the MetroPlus network. Depending on the reason why the provider left our network, you may be entitled to continue an ongoing course of treatment with that provider for a transitional period. If the provider is your OB/GYN and you are in the second trimester of pregnancy, you may continue care with that provider throughout your pregnancy, delivery and postpartum care related to the delivery. If you are seeing a provider regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days...
from the date the provider leaves MetroPlus. Your provider must agree to the following conditions:

1. Reimbursement rates applicable prior to start of transitional care;
2. Adhere to plan's quality assurance requirements;
3. Provide plan with necessary medical information related to this care;
4. Adhere to plan's policies and procedures.

Note: Transitional care is not allowed if the provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board or other governmental agency that impairs the health care professional's ability to practice.

If you want to receive transitional out-of-network care when you join MetroPlus or if your provider leaves the MetroPlus network, call MetroPlus GoldCare Member Services 877-475-3795 or TTY 711.

### Family Coverage

**SPOUSE AND DEPENDENTS**

MetroPlus GoldCare is available to employees of New York City Health and Hospitals Corporation, their spouse or qualified domestic partner, and any eligible dependent children under the age of 26. You will find the definitions of qualified domestic partner and dependent children in the MetroPlus GoldCare Certificate of Coverage.

**CHILDREN**

If you are an employee enrolled in MetroPlus GoldCare, your children who are under the age of 26, except for children who are eligible for employer-sponsored coverage, are eligible for MetroPlus GoldCare. The following are considered children:

- Natural children
- Legally adopted children
- Children whom the employee proposes to adopt and who are dependent upon the employee during the waiting period prior to adoption
- Newly born infants adopted by the employee if:
  - The employee takes physical custody of the infant upon the infant’s release from the hospital and the employee files a petition pursuant to New York State Domestic Relations Law, Section 115-c, within thirty (30) days of birth, and
  - Provided that no notice of revocation to the adoption has been filed pursuant to New York State Domestic Relations Law, Section 115-b, and
  - Consent to the adoption has not been revoked.

Please note: MetroPlus will not cover the infant’s initial hospital stay when a natural parent has insurance coverage available for the infant’s care.

- Children for whom the employee is the court appointed legal guardian and who are chiefly dependent upon the employee for support and maintenance
- Stepchildren who are dependent upon the employee for support and maintenance

See your Certificate of Coverage for further details.

In addition, an unmarried child as defined above who is age 26 and older and who is incapable of self-sustaining employment by reason of mental illness, development disability, mental retardation or physical handicap and who became so incapable prior to attaining age 26 is eligible for MetroPlus GoldCare. Such coverage shall not terminate while this Certificate of Coverage remains in effect and the child remains in such condition, if the employee submits proof of the child’s incapacity within thirty-one (31) days of the child attaining age 26.
You must add your newborn or newly eligible dependent to your coverage within 30 days of birth or becoming eligible. To do this, contact your Benefits Manager where you work, complete the required forms and return them to your Benefits Manager.

**YOUNG ADULT OPTION**

Unmarried children, who can no longer be covered under the parent’s policy due to age, may be eligible to purchase a separate policy which continues coverage afforded under the parent’s group health plan. To be eligible for this policy, the unmarried child must be under 30 years of age, not eligible for health insurance coverage through his/her own employer, live, work or reside in the MetroPlus service area, and not be covered by Medicare.

For current information on Eligibility, Enrollment Processes or Effective Dates of Coverage, please refer to the MetroPlus GoldCare Certificate of Coverage.

**Member’s General Responsibilities**

MetroPlus is committed to providing you and your family with prompt, courteous, quality health care. To get the best from MetroPlus GoldCare and its comprehensive benefits program, we ask you to do the following:

- Carry your MetroPlus GoldCare Member ID Card with you at all times.
- Keep your appointments and arrive 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.
- Let your PCP know of any change in your medical status, such as pregnancy or a recent Emergency Room visit or hospitalization.
- Obtain prior authorizations and written referrals when required by MetroPlus.

**Member’s Financial Responsibility**

You must pay for those services which:

- Are administered by a non-Participating Provider unless the services were specifically authorized by MetroPlus or constitute emergency services (see next page)
- Are provided without necessary prior authorization as required by MetroPlus
- Are provided in an Emergency Room but do not meet the criteria for emergency services
- Are not MetroPlus GoldCare Covered Benefits

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**Getting Care in Special Situations**

**SECOND OPINION FOR SURGERY**

If your PCP or a MetroPlus specialist recommends surgery, you may obtain a second opinion from a Participating Provider. This additional evaluation is usually scheduled to:

- Confirm surgery as the best course of treatment.
- Determine if other treatment is available to you. After a second opinion, recommendations will be discussed with you by both your PCP and an appropriate authorized specialist.

**SECOND OPINION FOR CANCER CARE**

If you are receiving medical care to diagnose or treat cancer, MetroPlus GoldCare benefits include a second opinion from a specialist. You are entitled to get a second opinion from an appropriate specialist or a specialist at a cancer specialty care center. The second opinion may be obtained from a Participating or non-Participating Provider; however, all treatment must be obtained from a Participating Provider. For MetroPlus to pay for the second opinion, you must get prior authorization from MetroPlus.

**WHAT IF YOU GET SICK ON THE JOB?**

If you get sick or have an accident at work, you must follow the procedure established by your place of employment. If you are examined by a medical professional on site or an Emergency Room and a follow-up visit is recommended, call your PCP’s office and arrange for any necessary follow-up.

**HIV TESTING AND COUNSELING**

All HIV testing and counseling is confidential. If you want to be tested, you can either visit your MetroPlus provider or go to a New York City or New York State anonymous testing program. No referral is required. For more information, you can call the New York State HIV/AIDS Information Service toll-free hotline at 800-541-2437.
AN EMERGENCY ROOM IS NOT ALWAYS THE BEST PLACE TO GO

If you have a problem that is not an emergency, please do not go to the Emergency Room. Call your PCP any time of the day or night. If you cannot reach your PCP, call MetroPlus GoldCare Member Services 877-475-3795 or TTY 711. Or, after business hours, call the MetroPlus After Hours Hotline at 800-442-2560. We will do our best to help you get the information and care that you need.

URGENT CARE

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

- This could be an episode of persistent vomiting or diarrhea
- It could be a sprained ankle, or a bad splinter you can’t remove

An urgent problem is serious, but Emergency Room services are not required. You can get an appointment for an urgent care visit for the same or next day. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call MetroPlus GoldCare Member Services 877-475-3795 or TTY 711. Or, after business hours, call the MetroPlus After Hours Hotline at 800-442-2560. We will do our best to help you get the information and care that you need.

However, in an emergency, dial 911 and follow instructions, or go immediately to the nearest Emergency Room.

EMERGENCY SERVICES

MetroPlus GoldCare benefits include emergency services. Emergency services are services that are medically necessary to stabilize or treat an emergency condition. An Emergency Condition is defined as:

A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;
2. Serious impairment to such person’s bodily functions;
3. Serious dysfunction of any bodily organ or part of such person; or
4. Serious disfigurement of such person.

Here are some examples of emergency conditions:

- a heart attack or severe chest pain
- bleeding that won’t stop or a bad burn
- broken bones
- trouble breathing/convulsions/loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have severe abdominal pain or cramps, vaginal bleeding, fever, vomiting or ruptured membranes (your water breaking or leaking)

Examples of non-emergencies are colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

In an emergency, call 911 and follow instructions, or go immediately to the nearest Emergency Room. Services for an Emergency Medical Condition do not require prior approval or authorization by your PCP or MetroPlus.

NOTE: If you go to an Emergency Room, you or someone acting on your behalf should contact your PCP to arrange for follow-up care.
Benefits

METROPLUS GOLDCARE BENEFITS* INCLUDE...

- All visits to your Primary Care Provider (PCP)
- Specialty services
- Initial and periodic physical examinations for adults and children, including well-child care
- All gynecological care, including Pap tests
- All maternity care
- Infertility diagnosis and treatment, EXCEPT reversal of elective sterilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT)
- All laboratory services, x-rays (including mammography, prostate and bone density screening), and other diagnostic tests and services ordered by your PCP or a specialist
- Short-term rehabilitation therapy
- Dialysis
- Emergency ambulance service
- Durable medical equipment
- Hospice care
- All diabetic medications and supplies
- Injectable drugs administered in a physician’s office
- Medically necessary vaccines including Gardasil for HPV prevention
- Care management programs for members with chronic diseases and other health issues
- All contraceptive medication and supplies for all women with reproductive capacity

HOSPITAL CARE*

Hospitalization at a MetroPlus network hospital is covered in full, when your admission is medically necessary, for any emergency illness or injury, and for any elective procedures ordered by your PCP or in-network specialist and prior authorized by MetroPlus.

Note: You or someone acting on your behalf should notify your PCP as soon as possible after an Emergency Room visit or hospital admission.

Covered services include:

- Unlimited number of hospital days, as medically necessary
- Maternity and newborn care
- Operating and recovery rooms, intensive care, special units and equipment, as well as post-operative care
- Physician services for medical and surgical conditions including second opinions
- Ambulatory surgery
- Anesthesia
- Radiation therapy and chemotherapy
- Pre-surgical testing
- Laboratory and x-ray services
- In-patient medication
- Inpatient acute medical rehabilitation

HOME HEALTH AND SKILLED NURSING FACILITY SERVICES*

The following services are covered when medically necessary and authorized by MetroPlus:

- Home health services: up to 200 home care visits per calendar year when a stay in a hospital or skilled nursing facility would otherwise have been required
- Skilled nursing facility: unlimited days per calendar year

MENTAL HEALTH, ALCOHOLISM AND SUBSTANCE ABUSE TREATMENT*

In-patient hospitalization and outpatient coverage for the following services are covered when medically necessary, authorized by a Participating Provider and MetroPlus and rendered in a facility approved by MetroPlus:

- Inpatient and outpatient mental health services
- Inpatient detoxification services
- Outpatient alcohol and substance abuse services
- Rehabilitation services for alcohol and substance abuse

*For complete information about Covered Services, exclusions and limitations, and other terms and conditions for coverage, please refer to the MetroPlus GoldCare Certificate of Coverage.
ACCESS TO END OF LIFE CARE*

Hospice services are available for members who are certified by their PCP as terminally ill (having a life expectancy of six (6) months or less to live). Terminally ill members may receive care in an acute-care facility or program that specializes in the treatment of terminally ill patients if the provider obtains an authorization from MetroPlus.

Appeal: If there is a dispute about admission to an acute care facility, MetroPlus will start an appeal and cover services while the appeal is pending.

PRESCRIPTION DRUGS

Prescription drugs are covered with a required co-pay when prescribed by an authorized MetroPlus provider and obtained from a participating pharmacy. Use your MetroPlus GoldCare Member ID Card to obtain authorized prescriptions at participating pharmacies. For a listing of participating pharmacies, check the MetroPlus website, www.metroplus.org, or call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711.

For information on the prescription mail order program, please see the enclosed brochure or visit www.caremark.com.

LIMITATIONS AND EXCLUSIONS*

MetroPlus does not cover medical or hospital services provided outside of the MetroPlus network except when:
- Your Provider has received written authorization/referral from MetroPlus for these services, or
- Services are required to stabilize or treat an emergency condition

MetroPlus does not cover any medical or hospital services that are covered by:
- Worker’s Compensation
- No-fault automobile insurance

MetroPlus does not cover services provided in:
- An institution providing maintenance therapy for chronic conditions
- An institution for bed rest and custodial care
- A skilled nursing facility unless the prescribed care has been prior authorized by MetroPlus

MetroPlus does not cover any service, test or treatment that MetroPlus determines is not medically necessary. MetroPlus does not cover the following services and conditions:
- Dental care, except in connection with a dental procedure in instances of accidental injury to sound natural teeth within twelve (12) months of the accident, or due to congenital disease or anomaly
- Cosmetic surgery except reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly
- Eye wear and eye exams related to the need for glasses or contact lenses
- Infertility services in connection with in vitro fertilization, gamete intrafallopian tube transfers (GIFT) or zygote intrafallopian tube transfers (ZIFT); reversal of elective sterilizations; sex change procedures; or cloning
- Routine foot care
- Services and treatment not based on generally accepted medical standards
- Experimental/Investigative services
- Private hospital rooms, unless medically necessary and authorized by MetroPlus
- Private duty nursing services
- Personal care services and long-term home care
- Coverage when the member is outside the U.S., Canada and Mexico
- Other non-covered services described in the MetroPlus GoldCare Certificate of Coverage

If you have any questions about what is or is not covered, refer to the MetroPlus GoldCare Certificate of Coverage or call MetroPlus GoldCare member Services at 877-475-3795 or TTY 711.

Note: Some services are covered through your Union Welfare Fund. Your Benefits Manager or Union Representative can provide you with details.

*For complete information about Covered Services, exclusions and limitations, and other terms and conditions for coverage, please refer to the MetroPlus GoldCare Certificate of Coverage.
Policies and Procedures

UTILIZATION REVIEW

MetroPlus Utilization Management (UM) will conduct Utilization Reviews whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. Requests for experimental or investigative health care services are also subject to utilization review.

PRIOR AUTHORIZATION

There are some treatments and services that you need to get approved before you receive them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request.

Your PCP can approve referrals to Participating Providers for:

- Specialty care
- Laboratory services
- Mental Health or Substance Abuse outpatient service
- Radiology (x-ray, MRI, CT, etc.)
- Hearing examinations and testing

You or your PCP must obtain prior authorization from MetroPlus before you:

- Are referred to a non-Participating Provider 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 or rehabilitation facility
- Receive home care services
- Obtain durable medical equipment (DME) including orthotics and prosthetics
- Obtain Growth Hormone, Lupron, Botox or Synagis injections in your physician’s office
- Obtain potentially cosmetic procedures

To obtain MetroPlus prior authorization for these treatments or services which require utilization review, you or your PCP need to contact MetroPlus GoldCare Member Services Department at 877-475-3795, TTY 711 or by fax 212-908-8521. A Member Services Representative will answer any questions you have about the process and will transfer your call to the Utilization Management Department, if needed. MetroPlus Utilization Management can be reached from 8:30 AM – 5:00 PM Monday through Friday.

You or your provider may also submit a service authorization request in writing by sending it to: MetroPlus Health Plan, Attention: Utilization Management, 160 Water Street, 3rd Floor, New York, NY 10038. If you need to reach MetroPlus Utilization Management after business hours, call the MetroPlus After Hours Hotline at 800-442-2560. MetroPlus Utilization Management staff will respond to your message on the next business day.

When you or your PCP requests prior authorization from the MetroPlus UM Department, the treatment plan will be checked against medical standards and a decision will be made. After we get your request, we will review it under a standard or fast track process. You or your provider 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.

MetroPlus will make a decision and inform you (or a person you designate) and your provider in writing and on the phone after we make a decision. We will also tell you the reason for the decision. We will explain what options for appeals you have if you do not agree with our decision. Failure by the Utilization Review agent or MetroPlus to make a determination within the required time periods set forth in Article 49 of the Public Health Law shall be deemed to be an adverse determination subject to internal appeal.

TIMEFRAMES FOR PRIOR AUTHORIZATION REQUESTS:

- Standard review: We will make a decision within three (3) business days of when we have all the information we need, but no later than fourteen (14) days after we receive the authorization request.
- Fast track review: We will make a decision and you will hear from us within three (3) business days. We will tell you by the third business day if we need more information.
- For utilization review determinations of home health care services following an inpatient hospital admission, MetroPlus will provide notice of its determination within one business day of receipt of the necessary information except within 72 hours of receipt of necessary information when the day subsequent to the request falls on a weekend or holiday. If a request for home health care services and all necessary information is provided to MetroPlus prior to a member’s inpatient hospital discharge, MetroPlus cannot deny the home care coverage request on the basis of a lack of medical necessity or a lack of prior authorization while the UR determination is pending. For the purposes of this section, the term inpatient hospital admission is limited to services provided to a member in a general hospital that provides inpatient care; this may include inpatient services in an Article 28 rehabilitation facility.
CONCURRENT REVIEW

When there is a need to continue or expand authorized treatment that you are currently receiving, you will also need to get continued authorization from the Utilization Management Department. This is called concurrent review.

**TIMEFRAMES FOR CONCURRENT REVIEW REQUESTS:**
- Standard review: We will make a decision about your request within one (1) business day of when we have all the information we need, but no later than fourteen (14) days after we receive the authorization request.
- Fast track review: We will make a decision within one (1) business day of when we have all the information we need, but you will hear from us no later than three (3) business days after we received your request. We will tell you by the third business day if we need more information.

RETROSPECTIVE REVIEW

We may review other treatments and services you have already received. This is called retrospective review.

**TIMEFRAMES FOR RETROSPECTIVE REVIEW:**
If the Utilization Management Department is reviewing care that has been given in the past, we will make a decision 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. If we fail to decide within the time limits stated above, the request is denied but you or your provider can appeal the denial.

NOTICE OF ADVERSE DETERMINATION

A decision that an admission, extension of stay, or other health care service, upon review based on the information provided, is not medically necessary is an adverse determination. 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 physician or may be a health care professional who typically provides the care you requested.

We will notify both you and your provider in writing if your request is denied and will include the reasons for the determination and instructions on how to initiate a standard or expedited appeal.

RECONSIDERATION

If MetroPlus made a decision about your service authorization request without talking to your provider, your provider may ask to speak with a MetroPlus Medical Director for reconsideration. The Medical Director will talk to your provider within one (1) business day.

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

APPEALS

**YOU CAN FILE AN APPEAL**
- If you are not satisfied with the determination that we make or what we decide about your service authorization request, you have 90 calendar days after hearing from us to file an appeal.
- You can appeal a denial of a requested out-of-network service on the basis that it is not materially different from an alternate in-network service by submitting:
  a. A written statement from your attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty area of practice appropriate to treat you for the health service sought, that the requested out-of-network health service is materially different from the health service the health care plan approved to treat your health care needs; and
  b. Two documents from the available medical and scientific evidence that the out-of-network health service is likely to be more clinically beneficial to you than the alternate recommended in-network health service and for which the adverse risk of the requested health service would likely not be substantially increased over the in-network health service.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call MetroPlus GoldCare Member Services 877-475-3795 or TTY 711 if you need help filing an appeal.
- The service that you receive from MetroPlus will not be affected because you file an appeal.
- The appeal can be made by phone or in writing. Written appeal requests should be sent to MetroPlus Health Plan, Attention: Appeals Coordinator, 160 Water Street, 3rd Floor, New York, NY 10038.
TIMEFRAMES FOR APPEALS

- **Standard appeals:** If we have all the information we need we will tell you our decision in thirty (30) business days from your appeal. A written notice of our decision will be sent within two (2) business days from when we make the decision.

- **Expedited appeals:** If we have all the information we need, expedited appeal decisions will be made in two (2) business days from your appeal. We will tell you in three (3) business 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. Expedited internal appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process or through the external appeal process.

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 MetroPlus to help decide your case. This can be done by calling MetroPlus Member Services at 877-475-3795, TTY 711 or writing to MetroPlus Health Plan, Attention: Appeals Coordinator, 160 Water Street, 3rd Floor, New York, NY 10038.

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

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

You or someone you trust can file a complaint with MetroPlus if you don't agree with our decision to take more time to review your 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 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 make a decision about your appeal within the required timeframe, the original denial will automatically be reversed, which means your service authorization request will be approved.
CONTINUATION OF SERVICES 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 (10) 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 results in another denial, you may have to pay for the cost of any continued benefits that you received.

EXTERNAL APPEALS

If MetroPlus decides to deny coverage for a medical service you and your provider asked for because it is not medically necessary, is prescribed for treatment of a rare disease or because it is experimental or investigational, or because a request for an out-of-network service was denied on the basis that an alternate in-network service was available and the member's provider certifies that the requested service (i.e. clinical trial or rare disease treatment) is materially different from, and likely to be more beneficial than, the in-network service, 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 review agents approved by New York State. The service must be in the MetroPlus GoldCare benefit package or be an experimental or rare disease treatment. You do not have to pay for an external appeal.

BEFORE YOU SUBMIT A REQUEST FOR AN EXTERNAL APPEAL TO THE STATE

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

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

Additional appeals to MetroPlus 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 MetroPlus gives you the notice of final adverse determination or when you and MetroPlus agreed to waive MetroPlus' appeal process.

YOU WILL LOSE YOUR RIGHT TO AN EXTERNAL APPEAL IF YOU DO NOT FILE AN APPLICATION FOR AN EXTERNAL APPEAL ON TIME

Here are some ways to get an application for an external appeal:

- Call the State Insurance Department at 800-400-8882
- Go to the State Insurance Department’s website at www.ins.state.ny.us
- Contact MetroPlus Member Services at 877-475-3795 or TTY 711 if you need help filing a request for an external appeal

The external appeal application will instruct you to send it to the NYS Department of Insurance. MetroPlus may charge the member a fee of up to $50 per external appeal. The fee will be refunded if the external appeal is decided in member’s favor. The member may obtain a waiver of this fee if the member meets MetroPlus' criteria for a hardship exemption. You and your doctors must release all pertinent medical information concerning your medical condition and request for services. An independent external appeal agent approved by the state will review your request to determine if the denied services are medically necessary and should be covered by MetroPlus. All external appeals are conducted by clinical peer reviewers. The agent’s decision is final and binding on both you and the plan.

Your external appeal will be decided in thirty (30) days. More time (up to five (5) business days) may be needed if the external appeal reviewer asks for more information. You and MetroPlus will be told the final decision within two days after the decision is made.

You can get a faster decision if your provider 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 MetroPlus the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If an external appeal of a concurrent adverse determination determines that the services are not medically necessary, the health care provider cannot collect payment from you except for the required copayments.
COMPLAINTS

MetroPlus GoldCare members have the right to make any kind of complaint. If you or your provider has a complaint about a MetroPlus decision to deny approval of a requested health care service because it is not medically necessary or it is experimental, you or your provider can appeal that decision using the procedure described in the Utilization Review Appeals section of this handbook (see pages 19-23). All other complaints, covered benefit, are handled through the Complaint Procedure described below.

MetroPlus’ goal is to ensure that our members receive quality health care and excellent customer service. If you are not satisfied with the level of care you receive or with any aspect of our services or benefits, you have a right to file a complaint.

Most complaints can be resolved immediately. If we do not resolve your complaint immediately over the telephone or if we receive your complaint in writing, we will respond to you in writing within 15 business days after we receive your complaint. The letter will include the name, address and telephone number of the person at MetroPlus who is investigating your complaint and what additional information, if any, is needed to resolve the complaint.

When a delay in resolving your complaint could significantly increase a risk to your health, we will make a determination within 48 hours after receipt of all necessary information and advise you of the outcome right away. If your complaint involves a request for referral or a question of covered benefits, we will make a determination within 30 days. In all other cases, we will make a determination within 45 days after receipt of all necessary information. MetroPlus will provide a written detailed explanation and reasons for the determination resulting from the investigation and the clinical rationale for those determinations with a clinical basis, without releasing protected peer review information. If we are unable to make a decision about your complaint because we do not have enough information to reach a determination, we will send a letter within 60 days.

HOW TO FILE A COMPLAINT

You or someone you choose to represent you can file a complaint by calling MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711 or in writing to: MetroPlus Health Plan • Attention: Complaints Manager, 160 Water Street, 3rd Floor, New York, NY 10038. You have the right to contact the New York State Department of Health at any time during the complaint process by calling their complaint hotline (800-206-8125) or writing to: NYS Department of Health, Office of Managed Care, 90 Church Street, New York, NY 10007.

COMPLAINT APPEALS

If you disagree with our response to your complaint, you can file a complaint appeal 60 business days after hearing from us. MetroPlus staff at a higher level than those who made the first decision will review grievance appeals. MetroPlus will send you a letter within fifteen (15) business days of when we receive your appeal. The letter will include the name, address, and phone number of the person at MetroPlus who is investigating your appeal and what additional information, if any, is needed to resolve the appeal. Reviewers will include qualified clinical staff when medical issues are involved. Appeals are decided within two (2) business days after receipt of all necessary information when a delay would significantly increase the risk to your health, and within 30 business days after receipt of necessary information in all other instances. MetroPlus will provide a notice of determination that will include a written detailed explanation and reasons for the determination resulting from the investigation; the clinical rationale for those determinations with a clinical basis without releasing protected peer review information; or a written statement that insufficient information was presented or available to reach a determination.

If you are still not satisfied with the way MetroPlus has resolved your complaint appeal, you can file a complaint at any time with New York State Department of Health by calling their complaint hotline (800-206-8125) or writing to: NYS Department of Health, Office of Managed Care, 90 Church Street, New York, NY 10007.

COORDINATION OF BENEFITS WITH OTHER PLANS

If you have another health plan in effect that covers the same service, MetroPlus will coordinate your benefits with the other plan. For more information, refer to the MetroPlus GoldCare Certificate of Coverage or call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711.

BENEFITS ELIGIBILITY EXTENSION

If you are a member of MetroPlus GoldCare and leave your job or lose your eligibility for any reason other than misconduct, you may be eligible to continue your MetroPlus GoldCare coverage through COBRA. For more information on this option, refer to the MetroPlus GoldCare Certificate of Coverage, or contact the Welfare Fund at 212-925-0005.

CONFIDENTIALITY OF INFORMATION

As a member of MetroPlus GoldCare, you are assured that all information on your care and treatment will be kept confidential in accordance with the law.

METROPLUS PROVIDER PAYMENT

MetroPlus either pays providers a fixed amount for each MetroPlus GoldCare member or pays providers for the services actually provided which are set in our provider contracts.
Members' Bill of Rights

The MetroPlus Members’ Bill of Rights gives members 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 and current information regarding a diagnosis, treatment and prognosis from a physician or other provider in terms the member can be reasonably expected to understand. When it is not advisable to give such information to the member, the information shall be made available to an appropriate person acting on the member’s behalf.

3. The right to be informed of the name, title and function of anyone involved in your care, as well as information about his/her 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 provider, 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.
Information Available on Request

The following information is available to you. To request it, please call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711.

- 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 written description of the organizational arrangements and ongoing procedures of MetroPlus' quality assurance program
- A description of the procedures followed in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials
- Information on the MetroPlus hospital affiliations of our MetroPlus 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
- Information on Advance Directives

Important Phone Numbers

For help from MetroPlus GoldCare Member Services, call 877-475-3795 or TTY 711 Monday through Saturday, 8 AM – 8 PM.

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:

<table>
<thead>
<tr>
<th>Name:</th>
<th>Phone Number:</th>
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<tbody>
<tr>
<td>PCP:</td>
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<td>OB/GYN:</td>
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If you need health care after hours or on weekends, call the MetroPlus After Hours Hotline: 800-442-2560. 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. Refer to the Emergency Services section of this handbook to find out what is a true emergency.

METROPLUS UTILIZATION REVIEW

For review of a MetroPlus decision that treatment is not medically necessary, call MetroPlus GoldCare Member Services at 877-475-3795 or TTY 711 and we will connect you with the Utilization Management Department if needed.

NYS DEPARTMENT OF HEALTH COMPLAINT HOTLINE: 800-206-8125
MetroPlus Health Plan Annual Privacy Notice

MetroPlus 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).

In addition, you can request a full text version of MetroPlus Health Plan’s Notice of Health Information Privacy Practices, which describes how medical information about you may be used and disclosed under the Federal Health Insurance Portability and Accountability Act (HIPAA) at any time by contacting the MetroPlus Privacy Officer. This information is also available on our website at www.metroplus.org/privacy-policies

What we do with your information:

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

• 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 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 with MetroPlus ends, your Information will remain protected in accordance with our policies and procedures for current members.

Contact MetroPlus

• 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.

Customer Services – MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038
General Phone: 1-800-303-9626, 7 days per week 8:00 a.m. to 8:00 p.m.
Medicare Members: 1-866-986-0356, 7 days per week, 8:00 a.m. to 8:00 p.m.
FIDA Members: 1-844-288-3432, 7 days per week, 8:00 a.m. to 8:00 p.m.
TTY: 711
E-mail: PrivacyOfficer@metroplus.org

Multi-Language Interpreter Services and Non-Discrimination

MetroPlus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MetroPlus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MetroPlus Health Plan:
If you believe that MetroPlus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

MetroPlus Health Plan, Attn: Complaints Manager
160 Water Street, 3rd Floor
New York, NY 10038
Phone: 1-800-303-9626 • Fax: 1-212-908-5196

You can file a grievance by mail, or by fax. If you need help filing a grievance, the MetroPlus Health Plan Grievance Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW, Room 509F, HHH Building,
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD).


Spanish: ATENCION: Si usted habla español, tiene a su disposición servicios de asistencia con el idioma. Llame a Servicios al Miembro de MetroPlus al 1-800-303-9626. Con gusto responderemos sus llamadas de lunes a sábado, de 8 a.m. a 8 p.m. Después de las 8 p.m., los domingos y días festivos: Servicio de Recepción de Llamadas, las 24 horas, 7 días a la semana llamando al 1-800-442-2560. La llamada es gratuita.

Chinese: 收件人：如果您说普通话，我们可为您提供语言协助服务。请拨打MetroPlus会员服务部电话：1-800-303-9626，我们的工作人员将于以下时间接电话：周一至周日，早8点至晚8点。我们将于8点半到8点接电话。如果您有其他问题，欢迎您拨打MetroPlus电话：1-800-303-9626。

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны услуги посредничества. Вы можете связаться с нами по телефону 1-800-303-9626. Мы будем рады принять ваш вызов с понедельника по субботу с 8 утра до 8 вечера. После 8 вечера по воскресным и праздничным дням: круглосуточно. Медицинская справочная служба по номеру 1-800-442-2560. Звонок бесплатный.

French: ATTENTION: Si vous parlez français, un service d’assistance vous est proposé. Appelez le service membre du MetroPlus au 1-800-303-9626. Nous serons heureux de vous répondre du lundi au samedi, de 8 h à 20 h Après 20 h, les dimanche & jours fériés : 24 h / 24, 7 j / 7 Service répondeur.

Italian: ATTENZIONE: Se Lei parla italiano, sono disponibili servizi di assistenza linguistica. Telefona ai servizi per i membri al numero 1-800-303-9626. Siamo felici di rispondere alle vostre richieste da lunedì a sabato, dalle 8 alle 20. Dopo le 20, la domenica e i festivi: 24/7 segreteria telefonica medica al numero 1-800-442-2560 La telefonata è gratuita.

Polish: UWAGA: Jeżeli mówisz po polsku, ma Cię o Twoich potrzebach udostępnione są usługi w Twoim języku. Zadzwoń do Punktu Usług dla uczestników programu MetroPlus pod numerem 1-800-303-9626. Czekamy na Twój telefon od poniedziałku do soboty w godzinach 8:00-20:00. Po godzinie 20:00, w niedziele i święta: Przyjmiemy zgłoszenia medyczne, dostępne 24/7 pod numerem telefonu 1-800-442-2560. Polaczenia telefoniczne są bezpłatne.


Greek: ΠΡΟΣΘΕΤΗ: Αν μιλάτε Ελληνικά, υπάρχουν στη διάθεσή σας υπηρεσίες βοήθειας στη γλώσσα σας. Επικοινωνήστε με την Υπηρεσία για Μέτρο της MetroPlus καλύτερα με τον αριθμό 1-800-303-9626. Είμαστε στη διάθεσή σας για να απαντήσουμε στις κλήσεις σας από δευτέρα έως Κυριακή, 8 μ.μ. - 8 μ.μ. Καθημερινά μετά τις 8 μ.μ., Κυριακές & Αρχές: Το 24ωρο. από 7
Your Information.
Your Rights.
Our Responsibilities.

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.

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We will charge you $0.75 (75 cents) for each page of copies you request.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
Your Rights (continued)

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we’ve shared information
- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- To ask for confidential communications, call our Member Services Department at 1-800-303-9626 (TDD 1-800-881-2812 or 711). Requests to change or modify this type of confidential communication request must be made in writing to the address listed below.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. 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 or 711).

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.
- We will not retaliate against you for filing a complaint.
Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

Example: We use health information about you to develop better services for you.

MetroPlus’ Quality Management Department may use your health information to help improve 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.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Reporting suspected abuse, neglect, or domestic violence

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

Address workers’ compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and actions

- We can share health information about you in response to a court or legal administrative order, or in response to a subpoena.

Privacy Officer Contact Information

If you have questions about our privacy practices, or if you want to file a complaint or exercise rights described above, please contact:

Customer Services – MetroPlus Health Plan
160 Water Street, 3rd Floor
New York, NY 10038
General Phone: 1-800-303-9626, 7 days per week 8:00 a.m. to 8:00 p.m.
Medicare Members: 1-866-986-0356, 7 days per week, 8:00 a.m. to 8:00 p.m.
FIDA Members: 1-844-288-3432, 7 days per week, 8:00 a.m. to 8:00 p.m.
TTY: 711
E-mail: PrivacyOfficer@metroplus.org

VIII. Multi-Language Interpreter Services and Non-Discrimination

MetroPlus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MetroPlus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MetroPlus Health Plan:
- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
  - TTY Services
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.
If you need these services, contact MetroPlus Member Services at 1-800-303-9626. We are happy to take your calls from Mon. - Sat. 8 am - 8 pm. After 8 pm, Sundays & Holidays: 24/7 Medical Answering Service at 1-800-442-2560. The call is free. For persons who have trouble hearing or speaking, please use our TTY number: 711

If you believe that MetroPlus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

MetroPlus Health Plan, Attn: Complaints Manager
160 Water Street, 3rd Floor
New York, NY 10038
Phone: 1-800-303-9626 • Fax: 1-212-908-5196

You can file a grievance by mail, or by fax. If you need help filing a grievance, the MetroPlus Medical Answering Service at 1-800-442-2560. The call is free. For persons who have trouble hearing or speaking, please use our TTY number: 711

Italian: ATTENZIONE: Se Lei parla italiano, sono disponibili servizi di assistenza linguistica. Telefonare ai servizi per i membri al numero 1-800-303-9626. Siamo felici di rispondere alle vostre richieste da lunedì a sabato, dalle 8 alle 20. Dopo le 20, la domenica e i festivi: 24/7 segreteria telefonica medica al numero 1-800-442-2560 La telefonata è gratuita.

Bengali: যদি আপনি বাংলা বলেন, আপনি লাইন নং 1-800-303-9626 দিয়ে বলুন অথবা ফেক্স দিয়ে বলুন। আপনি লাইনের সাহায্যে বিদ্যমান সেবা অফিসের সাথে যোগাযোগ করতে পারেন।

Russian: ВНИМАНИЕ: Если вы говорите на русском, вы можете воспользоваться помощью MetroPlus по телефону 1-800-303-9626. Если вы нуждаетесь в услугах на русском языке, вы можете связаться с нами по телефону 1-800-442-2560. Если вам нужна помощь, обратитесь в службу медицинского ответчика.

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OUR HEALTH PLAN FOR NEW YORK CITY DAY CARE WORKERS