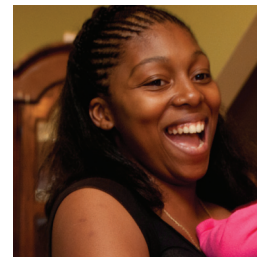
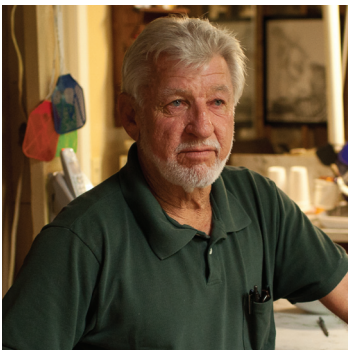


# Health Plus



Real



Solutions

## Member Handbook

New York





1-800-600-4441 ■ [healthplus.amerigroup.com](http://healthplus.amerigroup.com)

Dear Member:

Welcome to HealthPlus, an Amerigroup Company (HealthPlus Amerigroup)! Thank you for choosing us. HealthPlus Amerigroup offers health care coverage to members in the Bronx, Brooklyn, Manhattan, Staten Island, Queens and Nassau County.

Your membership will be effective on the first day of the month after you receive this letter. If you have not already chosen a Primary Care Provider (PCP) for each covered member of your family, please call our Member Services department at 1-800-600-4441 (TTY 1-800-855-2880). A Member Services representative will help you choose a PCP from the HealthPlus Amerigroup provider network. Once you have chosen a PCP, please make sure to schedule a baseline physical (regular checkup) as soon as you can. This is one way to get to know your PCP. If you need help scheduling a physical, call Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, call the toll-free AT&T Relay Service at 1-800-855-2880.

You can also call Member Services if you have questions about your benefits, need help or want to find out what services are available. When you call, you can speak with a Member Services representative or get in touch with a nurse on our 24-hour Nurse HelpLine about a related-topic or concern. This service is free. You can access our automated self-service features as well. You can take advantage of these services with our automated line 24 hours a day, 7 days a week:

- Choose or find a PCP in the HealthPlus Amerigroup network
- Update your address or phone number
- Request a member handbook or provider directory
- Change your PCP
- Request an ID card

You will receive a provider directory and a HealthPlus Amerigroup member ID card for each member within the first 14 days of enrollment. If you need to see a HealthPlus Amerigroup provider before the member ID card arrives, take this letter with you to the appointment. The provider will call to verify enrollment. Please read this handbook to learn about your benefits and find out how to make the best use of our services. You can get this information in another language. Just call Member Services at 1-800-600-4441. Si desea recibir más información en español, comuníquese con Servicios al Miembro al 1-800-600-4441. 若想获得此信息的中文版本, 请致电“会员服务” **1-800-600-4441**.

Check out our HealthPlus Amerigroup Nurse HelpLine. You can call our toll-free number at 1-800-600-4441 to talk to a nurse about a health-related topic or concern. This service is free. Please be sure to let us know if your address or phone number changes, so you can continue to receive important information, as well as occasional gifts from us. You can also tell us about your ideas and concerns.

Sincerely,

Member Services Department

You can call us from 9:00 a.m. to 6:00 p.m., Monday through Friday, or stop by one of our offices:

**BRONX**

2411 Grand Concourse  
718-933-9400

2501 Grand Concourse  
718-365-1890

**BROOKLYN**

2875 West 8th Street  
718-265-0040

3424 Church Avenue  
718-940-0351

364 Knickerbocker Avenue  
718-573-8530

5510 7th Avenue  
718-871-5510

4810 Fifth Avenue  
718-492-4399

815 59th Street  
718-435-9260

1220 Liberty Avenue  
1-888-809-8009

**MANHATTAN**

196 Canal Street  
212-732-3510

4234 Broadway  
212-568-0460

221 Sherman Avenue  
212-304-0512  
4764A Broadway  
1-888-809-8009

39-41 East Broadway #111  
1-888-809-8009

28 Bowery, Chinatown  
212-791-1400

**NASSAU**

91 N. Franklin Street,  
Hempstead  
516-292-2818

**QUEENS**

153-17 Jamaica Avenue  
718-297-4649

32-55 Steinway Street,  
Astoria 718-777-2401

37-88 103rd Street, Corona  
1-888-809-8009

102-06 Roosevelt Avenue,  
Corona  
1-888-809-8009

91-31 Queens Boulevard,  
Suite 222, Elmhurst  
718-205-7420

133-24 41st Avenue, Flushing  
1-888-809-8009

150-15 41st Avenue, Flushing  
718-460-0460

95-34 Roosevelt Avenue,  
Jackson Heights  
718-426-4912

116-03 Liberty Avenue,  
Richmond Hill  
718-848-9300

**STATEN ISLAND**

32 Richmond Terrace  
718-876-7575

HealthPlus Amerigroup is a culturally diverse company. We welcome all eligible individuals into our health care programs, regardless of health status. If you have questions or concerns, please call 1-800-600-4441 (TTY 1-800-855-2880) and ask for extension 34925. Or visit [healthplus.amerigroup.com](http://healthplus.amerigroup.com).

# HealthPlus Amerigroup

## New York State Family Health Plus Program

### Member Handbook

21 Penn Plaza, 360 W. 31st St., Fifth Floor  
New York, NY 10001  
1-800-600-4441 (TTY 1-800-855-2880)  
healthplus.amerigroup.com

This handbook will tell you how to use your health plan. Please put this handbook where you can find it when you need it. Here's where to find the information you want.

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# **WELCOME TO THE HEALTHPLUS AMERIGROUP FAMILY HEALTH PLUS PROGRAM**

We are glad that you chose HealthPlus Amerigroup! HealthPlus Amerigroup is committed to getting you the right care close to home. We want to be sure you get off to a good start as a new Family Health Plus 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, however, just call us at 1-800-600-4441.

## **How Managed Care Works**

### **HealthPlus Amerigroup, Our Providers and You**

You have probably seen or heard about the changes in health care. Many people now get their health benefits through managed care. Many counties/cities in New York State, including New York City, offer a choice of Family Health Plus managed care health plans. In some counties, however, there may only be one plan that offers Family Health Plus. Under Family Health Plus, people must join a managed care health plan in order to be able to receive health care benefits.

HealthPlus Amerigroup has a contract with the state Department of Health to meet the health care needs of people in Family Health Plus. In turn, we choose a group of health care providers to help us meet your needs. These doctors, 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 Member Services at 1-800-600-4441 to get a copy.

When you join our plans, one of our plan providers takes care of you. Most of the time, that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist or go into the hospital, your PCP will arrange for it. Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or on weekends, leave a message and say 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 Page 11 for details.

You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:

- Getting care from several doctors for the same problem
- Getting medical care more often than needed
- Using prescription medicine in a way that may be dangerous to your health
- Allowing someone other than yourself to use your plan ID card

## **How to Use This Handbook**

This handbook will help tell you how your new health care system will work and how you can get the most from HealthPlus Amerigroup. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.

The first part of this handbook will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or read a bit at a time.

When you have a question, check this handbook or call our Member Services department at 1-800-600-4441. You can also call the managed care staff at your Local Department of Social Services (LDSS). Be sure to tell them you are in the Family Health Plus Program. If you live in New York City, you can also call the New York Medicaid CHOICE HelpLine at 1-800-505-5678.

## Help from Member Services

There is someone to help you at Member Services from Monday through Friday 9:00 a.m. to 6:00 p.m. Call 1-800-600-4441. If you are deaf or hard of hearing, call the HealthPlus Amerigroup TTY at 1-800-855-2880.

If you need help or health care advice at other times, call 1-800-600-4441. Follow the options to speak with a nurse 24 hours a day, 7 days a week.

You can call to get help any time 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 a pregnancy or the birth of a new baby, or to ask about any change that might affect your benefits (for example, you get a job that offers health care coverage).

A HealthPlus Amerigroup representative will call you to explain our health plan and make sure you have access to the services you need right away. If you'd like to meet with a HealthPlus Amerigroup representative in person, call us to arrange a personal orientation at one of our community offices.

We offer free sessions to explain our health plan, and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that 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 speaks your language.

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

- A TTY/TDD machine (Our TTY phone number is 1-800-855-2880.)
- Information in large print
- Case management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

## Your HealthPlus Amerigroup ID Card

After you enroll, we'll send you a welcome letter. Your HealthPlus Amerigroup ID card should arrive within 14 days after your enrollment date. Your card has your PCP's name and phone number on it. It will also have your subscriber number (member number). If anything is wrong, call us right away. Your ID card has HealthPlus Amerigroup phone numbers on the back. 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. All the benefits that Family Health Plus covers can be accessed using your HealthPlus Amerigroup ID card.

## **Keep Us Informed**

Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number
- You have a change in circumstances that will affect your eligibility for Family Health Plus
- You are pregnant
- You give birth
- You become covered under another health insurance

## **Renewing Your Coverage**

To keep your Family Health Plus coverage, you will need to renew it annually. You will receive a notice in the mail reminding you to renew your coverage. You will be able to send your renewal form through the mail. If you do not return the information by the date given in the letter, your health care coverage will end.

Please do your part to keep your health insurance. If you need help completing the renewal package, you can go to one of our community offices, another enrollment facilitator or the HRA.

## **PART 1 — FIRST THINGS YOU SHOULD KNOW**

### **How to Choose Your Primary Care Provider**

You must pick a provider who is part of the HealthPlus Amerigroup network. You may have already picked your Primary Care Provider (PCP) to serve as your regular doctor. This person could be a doctor or a nurse practitioner who participates in the HealthPlus Amerigroup network. If you have not chosen a PCP, you should do so right away. If you do not choose a PCP 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 HealthPlus Amerigroup. 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 speak your language
- Who is easy to get to

Women can also choose one of our contracted OB/GYN doctors to deal with women's health issues. Women do not need a PCP referral to see a HealthPlus Amerigroup OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if there is a problem or regular care during pregnancy.

We also contract with 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. You may 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. They are listed below. See your provider directory, look at the list below or call Member Services for help at 1-800-600-4441.

### **HealthPlus Amerigroup Federally Qualified Health Centers**

#### **Amsterdam Avenue Family Health Center**

690 Amsterdam Avenue  
New York, NY 10025  
212-865-4104

#### **Beacon Christian Community Health Center Inc**

2079 Forest Ave  
Staten Island, NY 10303  
718-815-6560

#### **Bedford Stuyvesant Family Health Center**

1413 Fulton Street  
Brooklyn, NY 11216  
718-636-4500

#### **Betances Health Center**

280 Henry St # A  
New York, NY 10002  
212-227-8843

#### **Brooklyn Plaza Medical Center**

650 Fulton Street  
Brooklyn, NY 11217  
718-596-9800

#### **Brownsville Multi-services Family Health Center**

592 Rockaway Avenue  
Brooklyn, NY 11212  
718-345-5000

#### **Lutheran Medical Center**

150 55th Street  
Brooklyn, NY 11220  
718-630-7000

#### **Morris Heights Health Center**

85 W. Burnside Ave.  
Bronx, NY 10453  
718-716-4400

#### **Mt. Hope Family Practice**

1731 Harrison Ave.  
Bronx, NY 10453  
718-583-9000

#### **New Cassel/Westbury Health Center**

682 Union Ave,  
Westbury, NY 11590  
516-571-9535

#### **ODA Primary Care Health Center**

14 Heyward Street  
Brooklyn, NY 11211  
718-852-0803

#### **Park Slope Family Health Center**

220 13th Street  
New York, NY 11215  
718-832-5980

**Brownsville Multi-services Family Health Center at Genesis**  
592 Rockaway Avenue  
Brooklyn, NY 11212  
718-345-5000

**Charles B. Wang Community Health Center**  
125 Walker St.  
New York, NY 10013  
212-379-6988

**CHN - Betty Shabazz Health Center**  
999 Blake Avenue  
Brooklyn, NY 11208  
718-277-8303

**CHN - Bronx Center**  
975 Westchester Avenue  
Bronx, NY 10459  
718-991-9250

**CHN - CABS Center**  
94-98 Manhattan Avenue  
Brooklyn, NY 11206  
718-388-0390

**CHN - Caribbean House Center**  
1167 Nostrand Avenue  
Brooklyn, NY 11225  
718-778-0198

**CHN - Community League Center**  
1996 Amsterdam Ave  
New York, NY 10032  
212-781-7979

**Parkchester Family Practice**  
1597 Unionport Rd  
Bronx, NY 10462-5902  
718-822-1818

**Phillips Family Practice**  
16 E 16th St.  
New York, NY 10003  
212-206-5200

**Ramon S Velez Health Center**  
754 East 151 Street  
Bronx, NY 10455  
718-402-2800

**Refuah Health Center**  
Spring Valley Location  
728 North Main Street  
Spring Valley, NY 10977  
845-354-9300

**Refuah Health Center**  
Twin Location  
5 Twin Avenue  
Spring Valley, NY 10977  
845-354-9300

**South Fallsburg Location**  
South Fallsburg Family Medical  
36 Laurel Avenue  
South Fallsburg, NY 12779  
845-354-9300

**Roosevelt/Freeport Family Health Center**  
380 Nassau Road  
Roosevelt, NY 11575  
516-571-8600

**CHN - Downtown Health Center**

150 Essex Street  
New York NY 10002  
212-477-1120

**CHN - Helen B Atkinson Center**

81 W. 115th Street  
New York, NY 10026  
212-426-0088

**CHN - Queens Center**

97-04 Sutphin Boulevard  
Jamaica, NY 11435  
718-657-7088

**Community Health Center of Richmond**

235 Port Richmond Ave  
Staten Island, NY 10302  
718-876-1732

**Damian Family Care Center**

13750 Jamaica Avenue  
Jamaica, NY  
718-298-5100

**Dr. Martin Luther King, Jr. Health Center**

1265 Franklin Ave  
Bronx, NY 10456  
718-503-7700

**East 13th Street Family Practice**

113 East 13th Street  
New York, NY 10003  
212-253-1830

**Ryan/Chelsea-Clinton Community Health Center**

645 Tenth Avenue  
New York, NY 10036  
212-265-4500

**Ryan-Nena Community Health Center**

279 East Third Street  
New York, NY 10009  
212-477-8500

**Settlement Health & Medical Service**

212 East 106 Street  
New York, NY 10029  
212-360-2600

**Sidney Hillman Family Practice**

16 E 16th St  
(between 5th Ave & W Union Sq)  
New York, NY 10003  
212-924-7744

**Sunset Park Family Health Center**

150 55th Street  
Brooklyn, NY 11220  
718-630-7095

**Sunset Terrace Family Health Center**

514 49th Street  
Brooklyn, NY 11220  
718-431-2600

**Urban Health Plan - Bella Vista Health Center**

1065 Southern Boulevard  
Bronx, NY 10459  
718-589-2440  
212-517-1891

**EHCHS Inc. Boriken Neighborhood Health Center**

2253 3rd Avenue, 3rd Floor  
New York, NY, 10035  
212-289-6650

**Elmont Health Center**

161 Hempstead Turnpike  
Elmont, NY 11003  
516-571-8200

**Hempstead Health Center**

135 Main St.  
Hempstead, NY 11550-2414  
516-572-1300

**Hunt's Point Multi-Service Ctr - Ramon S Velez**

754 East 151 Street  
Bronx, NY 10455  
718-402-2800

**Institute for Family Health - Sidney Hillman Family Practice**

16 East 16th Street  
New York, NY 10003  
212-633-0800, ext. 1337  
212-206-5200 (medical)

**Joseph P. Addabbo Family Health Center**

67-10 Rockaway Beach Blvd.  
Averne, NY 11692  
718-945-7150

**Urban Health Plan - El Nuevo San Juan Health Center**

1065 Southern Boulevard  
Bronx, New York 10459  
718-589-2440

**Urban Health Plan - Plaza Del Castillo Health Center**

1515 Southern Boulevard  
Bronx, NY 10460  
718-589-1600

**Urban Horizons Family Practice**

50 East 168th Street  
Bronx, NY 10452  
718-293-3961

**Walton Family Health Center**

1894 Walton Avenue  
Bronx, NY 10453  
718-583-3060

**William F. Ryan Community Health Center**

110 West 97th Street  
New York, NY 10025  
212-316-7906

In almost all cases, your doctors will be HealthPlus Amerigroup providers. There are two instances when you can still see another doctor that you had before you joined HealthPlus Amerigroup. In both cases, however, your doctor must agree to work with HealthPlus Amerigroup:

1. You are more than three 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.

2. 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 from your date of enrollment with HealthPlus Amerigroup.

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. Please call Member Services, and they will help you make this change.

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 once every six months without cause or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.

If your provider leaves HealthPlus Amerigroup, 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. Your doctor must agree to work with HealthPlus Amerigroup during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-600-4441.

## **How to Get Regular Care**

Regular care means exams, regular checkups, shots or other treatments to help keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and let your PCP know 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:

- To prevent, or diagnose and correct what could cause more suffering
- To deal with a danger to your life
- To deal with a problem that could cause illness
- To deal with something that could limit your normal activities

Your PCP will take care of most of your health care needs — but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. If you can, 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. Your first visit to your PCP 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 you ask for an appointment:

<b>TYPE OF APPOINTMENT</b>	<b>YOU WILL BE SCHEDULED WITHIN</b>
Adult baseline and routine physicals	12 weeks
Urgent care	24 hours
Nonurgent sick visits	3 days
Routine, preventive care	4 weeks
First prenatal care visit during the first trimester	3 weeks
First prenatal care visit during the second trimester	2 weeks
First prenatal care visit during the third trimester	1 week
First newborn visit	2 weeks of hospital discharge
First family planning visit	2 weeks
Follow-up visit after mental health/substance abuse ER or inpatient visit	5 days
Nonurgent in-plan mental health/substance abuse treatment	2 weeks

If you cannot keep your scheduled appointment, please call and tell the doctor's office at least 24 hours before your scheduled appointment. You can also reschedule the appointment when you call.

### **How to Get Specialty Care and a Referral or a Script**

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, he or she will provide you with a referral or a script. You are not responsible for any costs except copayments as described later in this handbook. Copayments may apply for certain medical care and services. Most of these specialists are plan providers. If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. Talk with your PCP to find out how referrals work. If you think the 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 our plan to approve before you can get them. Your PCP will be able to tell you what they are. When your PCP refers you to a specialist, be sure to take your referral form or script with you to the specialist.

If you need to see a specialist outside our plan because we do not have a plan specialist who can meet your needs, talk to your PCP. You or your PCP on your behalf will need to ask for approval to be referred to a specialist outside our plan. Asking for coverage approval of a treatment or service, including a request for a referral or noncovered service is called a service authorization request.

Refer to the section, Service Authorization Request for details. If your PCP or HealthPlus Amerigroup refers you to a provider outside of our network, you are not responsible for any costs except the usual copayments as described later in this handbook.

Any decision to deny coverage of 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. Refer to the section, Service Authorization Appeals (Action Appeals) for details.

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 (this is called a standing referral). If you have a standing referral, you will not need a new referral for each time you need care from the same specialist.

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

- Your specialist to act as your PCP
- A referral to a specialty care center that deals with the treatment of your problem
- Hospice services if you are terminally ill
- If you are having trouble getting a referral you think you need, contact Member Services at 1-800-600-4441 (TTY 1-800-855-2880).

You can also call Member Services for help in getting access to a specialty care center.

## **Get These Services from HealthPlus Amerigroup without a Referral or a Script**

### **Women's Services**

You do not need a referral or a script from your PCP to see one of our participating providers twice a year if:

- You are pregnant or need a pregnancy test
- You need OB/GYN services
- You need family planning services
- You want to see a midwife
- You need to have a breast or pelvic exam

### **Family Planning**

You can get the following family planning services:

- Advice for birth control
- Prescription for birth control
- Pregnancy tests
- Sterilization
- A medically necessary abortion

During your visit, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam.

**You do not need a referral or a script** from your PCP to get these services. You can use your HealthPlus Amerigroup ID card to see one of the HealthPlus Amerigroup contracted family planning providers. Check the HealthPlus Amerigroup provider directory or call Member Services for help in finding a provider.

### **HIV Testing and Counseling**

You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP. Just make an appointment with a family planning provider.

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 New York State 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**

You do not need a referral from your PCP for an eye exam or to get new glasses. You just choose one of our participating providers. But remember that you are limited to eye exams and new glasses once every two years. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) exam once in any 12-month period.

### **Behavioral Health Assessment**

You may go for one mental health and one chemical dependence (including alcohol and/or substance abuse) assessment without a referral in any 12-month period. You must use a HealthPlus Amerigroup provider, but you do not need a referral from your PCP. If you need more visits, your PCP will help you get a referral.

### **Dental Care**

Covered services include regular and routine dental services, and supplies and devices required to alleviate health conditions; these services are provided by your primary care dentist. Professional services of a dentist for dental surgery performed in an inpatient or ambulatory setting are not covered.

### **Tuberculosis Services**

You can go to your PCP for diagnosis and treatment of tuberculosis (TB). Or you can go to a New York City Department of Health (NYC DOH) clinic for TB services. You do not need a referral to get these services from an NYC DOH clinic.

### **Emergencies**

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

- That comes on suddenly, 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 cause 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
- When you feel you might hurt yourself or others
- Broken bones
- Trouble breathing/convulsions/loss of consciousness
- If you are pregnant and have signs like pain, bleeding, fever or vomiting

Examples of nonemergencies are colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. Call your PCP for an appointment. You can also call Members Services to get the name of an urgent care center close by.

### **If You Believe You Have an Emergency**

If you believe you have an emergency, call 911 or go to the nearest emergency room. You do not need HealthPlus Amerigroup or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

If you are not sure, call your PCP or HealthPlus Amerigroup at 1-800-600-4441 and follow the options to speak with a nurse on the Nurse HelpLine, 24 hours a day, 7 days a week. Tell the person you speak with what is happening. Your PCP or a HealthPlus Amerigroup live nurse will:

- Tell you what to do at home
- Tell you to come to the PCP's office
- 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.**

### **Remember**

1. You do not need prior approval for emergency services.
2. Use the emergency room only if you have an emergency.
3. The emergency room should NOT be used for problems like the flu, sore throats or ear infections.
4. If you have questions, call your PCP or HealthPlus Amerigroup at 1-800-600-4441.

### **Nurse HelpLine**

If you are unsure whether to go to an emergency room or if you just need help with getting medical advice, you can call the HealthPlus Amerigroup Nurse HelpLine any time to help you with your health care questions. To speak to a nurse, please call the HealthPlus Amerigroup Nurse HelpLine at 1-800-600-4441 and follow the options to speak with a nurse 24 hours a day, 7 days a week.

### **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.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-600-4441 and follow the prompts to speak with a nurse 24 hours a day, 7 days a week. Tell the person who answers what is happening. He or she will tell you what to do.

### **Care Outside of the United States**

Any care received outside of the United States, District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa will not be covered by HealthPlus Amerigroup.

## **We Want To Help Keep You Healthy**

Besides the regular checkups you need, here are some other ways to help keep you in good health:

- Prenatal visits to your home
- Postnatal visits to your home
- Prenatal care and nutrition
- Stop smoking resources
- Cholesterol control
- Summer health camps
- Breastfeeding and baby care
- Asthma education
- Story-time readings for kids
- Nurse HelpLine
- Cervical and breast cancer prevention
- Dental health education
- Weight control
- Grief/loss support
- Stress management
- Health education in your member newsletter
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Health education classes for young children and their families

Call Member Services at 1-800-600-4441 if you want to join a program. You can also get a list of upcoming classes.

## **HealthPlus Amerigroup Outreach Program**

To help you stay healthy, the HealthPlus Amerigroup Outreach team will call you from time to time. An Outreach representative will see if you have gotten recommended preventive services and can help you make appointments. Recommended services include:

- Annual physicals
- Annual dental visits
- Cervical cancer screening
- Breast cancer screening
- Care for diabetics

Outreach is done by mail and through telephone calls and home visits when appropriate. This ensures children are kept current with respect to their vaccines and well-child checkup schedules. The Outreach representative will help you make an appointment to see your PCP, dentist or OB/GYN if you have not received these services.

## **Disease Management Centralized Care Unit**

HealthPlus Amerigroup has a Disease Management Centralized Care Unit (DMCCU) program. A team of licensed nurses and social workers, called DMCCU care managers, educate you about your condition and help you learn how to manage your care. Your Primary Care Provider or PCP and our team of DMCCU care managers will assist you with your health care needs.

DMCCU care managers provide support over the phone for members with:

- Diabetes
- HIV/AIDS
- Heart conditions
- Coronary artery disease
- Congestive heart failure
- Hypertension
- Lung conditions
- Asthma
- Chronic obstructive pulmonary disease
- Behavioral health conditions
- Bipolar disorder
- Major depressive disorder
- Schizophrenia

DMCCU care managers work with you to create health goals, and help you develop a plan to reach them. As a member in the program, you will benefit from having a care manager who:

- Listens to you and takes the time to understand your specific needs
- Helps you create a care plan to reach your health care goals
- Gives you the tools, support and community resources that can help you improve your quality of life
- Provides health information that can help you make better choices
- Assists you in coordinating care with your providers

As a HealthPlus Amerigroup member enrolled in the DMCCU, you have certain rights and responsibilities. You have the right to:

- Have information about HealthPlus Amerigroup. This includes all HealthPlus Amerigroup programs and services as well as our staff's education and work experience. It also includes contracts we have with other businesses or agencies.
- Refuse to take part in or disenroll from programs and services we offer
- Know which staff members arrange your health care services and who to ask for a change
- Have HealthPlus Amerigroup help you to make choices with your doctors about your health care
- Learn about all DMCCU-related treatments; these include anything stated in the clinical guidelines, whether covered by HealthPlus Amerigroup or not; you have the right to discuss all options with your doctors
- Have personal and medical information kept private under HIPAA; know who has access to your information; know what HealthPlus Amerigroup does to keep it private
- Be treated with courtesy and respect by HealthPlus Amerigroup staff
- File a complaint with HealthPlus Amerigroup and be told how to make a complaint; this includes knowing about HealthPlus Amerigroup standards of timely response to complaints and resolving issues of quality
- Get information that you can understand
- Have HealthPlus Amerigroup act as an advocate for you if needed

You are encouraged to:

- Listen to and know the effects of accepting or rejecting health care advice
- Provide HealthPlus Amerigroup with information needed to carry out our services
- Tell HealthPlus Amerigroup and your doctors if you decide to disenroll from the DMCCU program

If you have one of these conditions or would like to know more about our DMCCU, please call 1-888-830-4300, Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time. Ask to speak with a DMCCU care manager. You can also visit our website at [healthplus.amerigroup.com](http://healthplus.amerigroup.com).

## **PART 2 — YOUR BENEFITS AND PLAN PROCEDURES**

The rest of this handbook is for your information when you need it. It lists the covered and noncovered services available under Family Health Plus. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

## Benefits

Family Health Plus covers a comprehensive set of health care services or benefits. HealthPlus Amerigroup will provide or arrange for all of the covered services. You can get a few services, though, without going through your PCP. These include emergency care, family planning/HIV testing and counseling, and specific self-referral services, as mentioned in Part 1.

## Copayments

Family Health Plus members are required to make copayments when receiving certain medical care and services. Some people are exempt and do not have to make these payments. See the following list of services that require copayments and information about who is exempt.

Service	Copayment
Brand-name prescription drugs	\$6 for each prescription and refill
Generic prescription drugs	\$3 for each prescription and refill
Clinic visit	\$5 per visit
Physician visit	\$5 per visit
Dental service visit	\$5 per visit up to a total of \$25 per year
Lab tests	\$0.50 per test
Radiology services (like diagnostic X-rays, ultrasound, nuclear medicine and oncology services)	\$1 per radiology service
Inpatient hospital stay	\$25 per stay
Nonurgent emergency room visit	\$3 per visit
Over-the-counter medications (only for smoking cessation and insulin)	\$0.50 per medication
Medical supplies (only for diabetes and enteral formulae)	\$1 per supply

If you have questions, you may call Member Services at 1-800-600-4441 or the Department of Health's Family Health Plus Information Line at 1-877-934-7587. If you have pharmacy benefit questions, please call the Medicaid Help Line at 1-800-541-2831.

Certain medications may require that your doctor get prior authorizations from us before writing your prescription. Your doctor can work with HealthPlus Amerigroup to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at 1-800-600-4441 (TTY 1-800-855-2880).

Copayments do not apply to the following services:

- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Mental illness drugs (psychotropic)
- Tuberculosis drugs
- Prescription drugs for a resident of an adult care facility

You do not have to pay the copayments if you are:

- Under age 21
- Pregnant
- A resident of a community-based residential facility licensed by the Office of Mental Health or the Office for People with Developmental Disabilities
- Not able to pay the copayment at any time, and you tell the provider that you are unable to pay

Family Health Plus members who cannot afford the copayment may not be denied a service based on their inability to pay.

Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid copay amounts to the provider, and the provider may ask you for payment later or send you a bill.)

### **Services Covered by HealthPlus Amerigroup**

You must get these services from HealthPlus Amerigroup providers. All services must be medically necessary and provided or referred by your PCP.

#### **Regular Medical Care**

- Office visits with your PCP
- Referrals to specialists
- Eye and hearing exams

#### **Preventive Care**

- Regular checkups
- Tests and procedures ordered by your PCP or specialist
- Access to Early Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees age 19 and 20 years old
- Smoking cessation counseling; enrollees are eligible for six sessions in a calendar year

#### **Maternity Care**

Women in Family Health Plus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size is changed. If you become pregnant while you are enrolled in Family Health Plus, you have a choice to make. You may want to change coverage from Family Health Plus to Medicaid. Medicaid covers more services than Family Health Plus, which you may or may not need, depending on your medical needs. However, you may need to see a different doctor if you change from Family Health Plus to Medicaid. You should discuss this choice with your doctor and the Local Department of Social Services office or HRA so that you can make the decision that best meets your needs.

Your baby will be eligible for Medicaid. Babies can't be covered under Family Health Plus; it is a program for adults from 19 through 64 years of age. In order to be sure your baby will have access to all the services covered by Medicaid, you need to let your local Department of Social Services or HRA office know when you are pregnant, and your doctor should notify HealthPlus Amerigroup.

They can get started arranging for coverage for your baby before it is born, regardless of the choice you have made for yourself. You should select your baby's doctor as soon as possible.

If you stay in Family Health Plus, we will cover:

- Pregnancy care
- Doctors/midwife and hospital services
- Postpartum care

*Taking Care of Baby and Me* is the HealthPlus Amerigroup program for all pregnant members. When you are pregnant, HealthPlus Amerigroup will send you a pregnancy education package. It will include:

- A letter welcoming you to the *Taking Care of Baby and Me* program
- A self-care book
- *Taking Care of Baby and Me* reward program brochure

The self-care book gives you information about your pregnancy. You can also use the book to write down things that happen during your pregnancy. The *Taking Care of Baby and Me* brochures tell you how to get your gifts for getting prenatal care.

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants and Children Program (WIC). Member Services can give you the phone number for the WIC program close to you. Just call us.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every four weeks for the first six months
- Every two weeks for the seventh and eighth months
- Every week during the last month

Your PCP or OB/GYN may want you to visit more than this based on your health needs.

When you deliver your baby, you and your baby may stay in the hospital at least:

- Forty-eight hours after a vaginal delivery
- Ninety-six hours after a Cesarean section (C-section)

You may stay in the hospital less time if your PCP or OB/GYN and the baby's doctor see that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

Remember to call HealthPlus Amerigroup Member Services as soon as you can to let us know that you had your baby. We will need to get information about your baby, too. You may have already picked a PCP for him or her.

After you have your baby, HealthPlus Amerigroup will send you the *Taking Care of Baby and Me* postpartum education package. It will include:

- A letter welcoming you to the postpartum part of the *Taking Care of Baby and Me* program
- A baby-care book

- *Taking Care of Baby and Me* reward program brochure about going to your postpartum visit
- A brochure about postpartum depression

You can use the baby-care book to write down things that happen during your baby's first year. This book will give you information about your baby's growth.

### **Home Health Care**

HealthPlus Amerigroup can arrange for some home health care visits (up to 40 per year), but this is generally only done to avoid your having to stay in a hospital. Your doctor must agree that your medical needs can be met at home with this help. Here are some times when this would be covered:

- One medically necessary postpartum home health visit; additional visits as medically necessary for high-risk women
- Other visits as needed and ordered by your PCP/specialist

### **Vision Care**

Members have the option to pay as private customers for nonstandard lenses not covered by us, and we can pay for the standard frames. Members can also pay as private customers for nonstandard frames not covered by us, and we can pay for the standard lenses. Members can also go to free clinics affiliated with the College of Optometry of the State University of New York without a referral or prior authorization from us.

Family Health Plus covers emergency vision care and the following preventive and routine vision care provided once in any 24-month period:

- One eye exam
- Either one pair of prescription eyeglass lenses and a frame or prescription contact lenses where medically necessary
- One pair of medically necessary occupational eyeglasses. Occupational eyeglasses are special glasses that help you perform your job duties

### **Dental Care**

HealthPlus Amerigroup believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, a company focused on providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleanings, X-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist!

### **How to Access Dental Services**

Once you enroll in HealthPlus Amerigroup, you will receive a letter from our Member Services department letting you know it is time to choose your PCD. You must choose a PCD within 30 days from the date of this letter, or we will choose one for you.

- If you need to find a dentist or change your dentist, please call Healthplex toll free at 1-800-468-9868 (TTY: 1-800-662-1220), 8:00 a.m. to 6:00 p.m., Monday through Friday. Member service representatives are there to help you. Many speak your language or have a contract with language line services.

- Show your member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.
- You can also self-refer to a dental clinic that is run by an academic dental center. For more information on how to find an academic dental center, please call Member Services at 1-800-600-4441.

As part of your dental benefit, you will have a Primary Care Dentist (PCD) who is part of the Healthplex network of dentists. You will see your PCD for all of your general dental needs. If you need care that your PCD cannot give, he or she will refer you to a specialist.

If you wish to change your PCD, you may do so at any time. Call Healthplex to choose a new PCD or if you have questions about your dental benefits. We encourage you to call your PCD as soon as you can for a dental checkup. This will let your dentist find out what your dental needs are and let you discuss any dental concerns you may have. When you call to set up your first dental visit, tell the office you are a HealthPlus Amerigroup member.

If you have a dental emergency, call your PCD's office. If you have a problem reaching this dentist, call Healthplex for help in getting emergency dental care.

### **Hospital Care**

- Inpatient care
- Outpatient care
- Lab, X-rays and other tests

### **Hospice Services**

Hospice care is a coordinated program of home and inpatient services which provide nonhealing medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six months or less.

Family members are eligible for up to five visits for bereavement counseling.

### **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. These are called poststabilization services.
- See the section on emergency services for more information.

### **Behavioral Health Services**

HealthPlus Amerigroup will cover up to 60 outpatient visits and 30 inpatient visits a year for behavioral health services. Behavioral services include chemical dependence services (including alcohol and substance abuse services) and mental health treatment services.

Detoxification services (inpatient detoxification and inpatient or outpatient withdrawal services) do not count towards the limits mentioned above.

## Specialty Care

Includes the services of other providers, including:

- Occupational, physical and speech therapists — limited to 20 visits per therapy per calendar year.
- Midwives
- Audiologists
- Cardiac rehabilitation

## Other Covered Services

- Emergency transportation
- Durable medical equipment
- Hearing aids/supplies
- Prosthetics/orthotics
- Dental
- Court-ordered services
- Tuberculosis (TB) diagnosis and treatment — You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency

## Pharmacy Benefit

Family Health Plus members must use their HealthPlus Amerigroup ID card to get prescription drugs, smoking cessation products, including insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets and alcohol wipes), hearing aid products, diabetic supplies, enteral formulae and select Over-The-Counter (OTC) products such as Prilosec OTC, Loratadine, Zyrtec and vitamins, and hearing aid batteries. You must use a pharmacy that accepts our plan.

Copayments apply for most medicines. Some members are not required to pay these copayments. For a list of copayments, refer to the copayment chart.

Certain medicines may require that your doctor get prior authorization from HealthPlus Amerigroup before writing your prescription. Your doctor can work with HealthPlus Amerigroup to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.

## Transportation for Family Health Plus

For members 19 through 20 years old who are in the C/THP program, LogistiCare manages nonemergency or routine trips to medically necessary medical appointments. Transportation is available in the Bronx, Brooklyn, Manhattan, Staten Island, Queens and Nassau County.

**However, if you have a medical emergency and need emergency transportation, call 911.**

To schedule a routine ride to a medical appointment, call LogistiCare at least 48 hours ahead of time at:

- Reservation line: 1-866-481-9488
- Ride Assist: 1-866-481-9489

LogistiCare is available Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern time. They can also help you schedule a return ride after your appointment. Just call the reservation line number. To arrange a replacement ride if your scheduled ride is more than 15 minutes late, call the Ride Assist number.

## **Services Not Covered by HealthPlus Amerigroup**

These services are not available from HealthPlus Amerigroup. If you get any of these services, you may have to pay the bill. Also, if you agree to be a private-pay patient before you get a service, you will have to pay for the service.

- Cosmetic surgery if not medically needed
- Services of a podiatrist (for those 21 years and older)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of HealthPlus Amerigroup (unless HealthPlus Amerigroup or your PCP sends you to that provider)
- Those services not given an approval in advance by your PCP
- Personal care services
- Private duty nursing services
- Medical supplies (like bandages), nonprescription drugs (OTCs like aspirin)
- Nursing home stays that are permanent
- Physical exams for the purpose of employment
- Nonemergency transportation (unless you are 19 or 20 and in the C/THP program)
  - To get nonemergency transportation, you or your provider must call LogistiCare at 1-866-481-9488 for reservations and Ride Assist at 1-866-481-9489 to arrange for a replacement ride. If possible, you or your provider should call LogistiCare at least three days before your medical appointment and provide your appointment date and time, address where you are going, and the doctor you are seeing. Nonemergency transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

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 or self-pay patient, you will have to pay for the service. This includes:

- Noncovered services (listed above)
- Unauthorized services
- Services provided by providers not part of HealthPlus Amerigroup

If you have any questions, call Member Services at 1-800-600-4441.

## **How Our Providers Are Paid**

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at 1-800-600-4441 if you have specific concerns.

We also want you to know that most of our providers are paid in one or more of the following ways:

- Our PCPs may get a set fee each month for each member who chose that provider as his or her PCP. The fee stays the same whether the member needs one visit or many — or even none at all. This is called capitation.
- HealthPlus Amerigroup also pays additional incentives for providers when they provide recommended preventive care services for their members on a fee-for-service basis
- Providers may also be paid by fee-for-service. This means they get an HealthPlus Amerigroup agreed-upon fee for each service they provide

## **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, please tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-600-4441 to find out how you can help.

## **Information from Member Services**

Here is information you can get by calling Member Services at 1-800-600-4441:

- A list of names, addresses and titles of the HealthPlus Amerigroup Board of Directors, officers, controlling parties, owners and partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about HealthPlus Amerigroup
- How we keep your medical records and member information private
- In writing, we will tell you how our plan checks on the quality of care to our members
- 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 our plan
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our 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

## **Options for Disenrollment**

### **If You Want to Leave HealthPlus Amerigroup**

You can try us for 90 days. You can ask to leave our plan for any reason at any time during those 90 days if there is another Family Health Plus plan available where you live.

If you do not leave during the first 90 days of your coverage, you must stay in the plan for nine more months unless you have a good reason (good cause). At the end of your first year in our plan, if you want to, you can change to another plan if there is another Family Health Plus plan available where you live.

These are examples of good cause:

- We cannot provide a suitable PCP for you within acceptable travel times (30 minutes or 30 miles from your home, if that's what's usual where you live)
- 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
- We do not offer a Family Health Plus covered service that you can get from another Family Health Plus plan
- 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

Call New York Medicaid CHOICE at 1-800-505-5678 and tell them you want to transfer to another Family Health Plus plan. You will need to get a Transfer Package that will tell you what other plans are available where you live. The transfer package will also have two forms.

You will need to fill out the Disenrollment Form for HealthPlus Amerigroup. Members with HIV/AIDS can request a transfer from HealthPlus Amerigroup to an HIV Special Needs plan or another health plan at any time.

You will also need to choose another health plan. You will need to fill out the Enrollment Form for the new plan. Fill out the forms and mail them to New York Medicaid CHOICE. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

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 Department of Social Services or New York Medicaid CHOICE.

### **If You Become Ineligible for the HealthPlus Amerigroup Family Health Plus Program**

You may have to leave HealthPlus Amerigroup if you:

- Move out of the county or service area
- Have a change in income that makes you ineligible for Family Health Plus
- Join an HMO or other insurance plan through work
- Receive Medicare coverage
- Join a long-term home health care program
- Are incarcerated
- You turn 65 years of age

You are guaranteed coverage by HealthPlus Amerigroup during the first six months of your enrollment — even if you are no longer eligible for Family Health Plus. The reasons for your losing eligibility must not be related to death, moving out of state or incarceration.

During this time, you can get the services that our plan covers. Guaranteed coverage does not apply if you choose to leave HealthPlus Amerigroup.

## **We Can Ask You to Leave HealthPlus Amerigroup**

You can also lose your membership in HealthPlus Amerigroup if you often:

- Refuse to work with your PCP in regard to your care
- Don't keep appointments
- Go to the emergency room for nonemergency care
- Don't follow HealthPlus Amerigroup rules
- Do not fill out forms honestly or do not give true information (fraud)
- Cause abuse or harm to plan members, providers or staff
- 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

## **You May Want to Change from Family Health Plus to Medicaid with a Spend Down**

Family Health Plus doesn't cover all the services that Medicaid does (like medical supplies), and some Family Health Plus services have limits that Medicaid doesn't. If you have medical needs that could be better met by Medicaid and you qualify, you may be eligible for Medicaid with a spend down.

If your income is higher than that allowed for Medicaid, but you have medical bills that are greater than the amount your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:

- Are under age 21
- Are disabled or blind
- Have children under age 21
- Are over age 65
- Are pregnant (see below also)

You should contact your Local Department of Social Services or HRA to see if this is an option for you. If so, they will have you disenroll from HealthPlus Amerigroup so that you can receive Medicaid benefits. You can ask that this be done quickly if you feel that waiting will damage your health or if you have complained because you did not agree to the Family Health Plus enrollment.

## **If You Become Pregnant While Enrolled in Family Health Plus**

If you become pregnant, you are eligible for Medicaid. You have the choice of staying in Family Health Plus or changing to Medicaid. You may decide to change to Medicaid because it covers more services. You can stay in HealthPlus Amerigroup, but you should ask your doctor if he would continue seeing you as a Medicaid patient, if you change.

Your newborn will automatically be eligible for Medicaid and will be enrolled in HealthPlus Amerigroup. You should contact HealthPlus Amerigroup and your local Department of Social Services office or HRA to discuss these options and your decision.

## SERVICE AUTHORIZATION AND ACTIONS

### Prior Authorization and Time Frames

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. The following treatments and services must be approved before you get them:

- Most ambulatory surgery
- Chemotherapy
- Dialysis
- Durable medical equipment
- Genetic testing
- Lithotripsy
- Hearing aids
- Home care
- Hyperbaric oxygen therapy
- Inpatient admission
- Growth hormone evaluation and therapy
- Nonemergency ambulance
- Obstetrical services (except family planning services)
- Oxygen equipment — respiratory therapy
- Prosthetics and orthotics
- Physical therapy, occupational therapy, speech therapy
- Transplant evaluation

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 includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called concurrent review.

Asking for coverage approval of a treatment or service, including a request for a referral or noncovered service, is called a service authorization request. To get approval for these treatments or services:

- You or your doctor needs to call the HealthPlus Amerigroup Medical Management department at 1-800-454-3730.

If necessary, your doctor can call for an approval after hours and weekends by calling this number. If you have any questions, call the Member Services department at 1-800-600-4441.

### Service Authorization Requests

The health plan has a Medical Management team to be sure you get the services we agree to when you ask for a service authorization. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is covered (medically needed and allowed under your plan). They do this by checking your treatment plan against medically acceptable standards.

Any decision to deny coverage of 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 coverage 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.

### What Happens After We Get Your Service Authorization Request

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. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast-track review. 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.

#### **Time Frames for Prior Authorization Requests**

- Standard review: We will make a decision about your request within three workdays of when we have all the information we need. If we do not have all of the information we need to review your request, we will let you know no later than 14 days after we receive your request for review.
- Fast-track review: We will make a decision and you will hear from us within three workdays after we receive all of the information we need to review your request. We will tell you by the third workday if we need more information in order to make a decision on your review request.

If HealthPlus Amerigroup receives a request for home health care during a hospital admission or immediately after you are discharged from the hospital, we will process that request as an expedited review and make a decision within one workday. In cases where the request is made on a Friday or the day before a holiday, notice of a decision must be sent within 72 hours of receipt of the necessary information.

#### **Time Frames for Concurrent Review Requests**

- Standard review: We will make a decision within one workday of when we have all the information we need. If we do not have all of the information we need to review your concurrent review request, we will let you know no later than 14 days after we receive your concurrent review request.
- Fast-track review: We will make a decision within one workday of when we have all the information we need to make a decision. However, if you are in the hospital or have just left the hospital and you ask for home health care on a Friday or the day before a holiday, we will make a decision no later than 72 hours of when we have all the information we need. In all cases, you will hear from us no later than three workdays after we received your request. We will tell you by the third workday if we need more information in order to make a decision.

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 1-800-600-4441 or writing to us at:

Director of Member Services  
HealthPlus, an Amerigroup Company  
21 Penn Plaza  
360 W. 31st St., Fifth Floor  
New York, NY 10001

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 coverage request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Service Authorization Appeals (Action Appeals) 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 your care is still covered. 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.

### **Time frames for notice of other actions:**

- In most cases, if we make a decision to reduce, suspend or terminate coverage of 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 coverage 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 was covered by the plan or by Family Health Plus even if we later deny payment to the provider.

## **Service Authorization Appeals (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, including a request for a referral or noncovered service, is called a service authorization request. This process is described earlier in this handbook. Any decision to deny coverage of 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 that your service authorization request was not medically necessary, or was experimental or investigational and we did not talk to your doctor about it, your doctor may ask to speak with the plan's medical director. The medical director will talk to your doctor within one workday.

## **You Can File a Service Authorization Action Appeal**

If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 workdays after hearing from us to file an action appeal. You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services at 1-800-600-4441 if you need help filing an action appeal.

We will not treat you any differently or act badly toward you because you filed an action appeal. The action appeal can be made by phone or in writing. If you make an action appeal by phone it must be followed up in writing to:

Medical Appeals  
HealthPlus, an Amerigroup Company  
P.O. Box 62429  
Virginia Beach, VA 23466-2429

Your service authorization action appeal will be reviewed under the fast-track process:

- If you or your doctor asks to have your action appeal reviewed under the fast-track process. Your doctor will 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 action appeal will be reviewed under the standard process.
- 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. See the section Time Frames for Service Authorization (Action Appeals) for more information.

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?**

In the case of a standard appeal, we will send you a letter to let you know we are working on your action appeal. This letter will be sent within 15 days of HealthPlus Amerigroup receiving your action appeal.

Service authorization 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.

Nonclinical 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 action 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. You can provide the information in person or in writing.

Call HealthPlus Amerigroup at 1-800-600-4441 if you are not sure what information to give us.

If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:

- A written statement that the service you asked for is different from the service we have in our network
- Two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you and will not cause you more harm than the service we have in our network

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 to you or your personal representative. For further appeals, you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

### **Time frames for service authorization action appeals**

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

**Fast-track appeals:** If we have all the information we need, fast-track action appeal decisions will be made in two business days from your action appeal. We will tell you in three 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. If we need more information to make a standard or fast-track decision about your service coverage authorization 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 health plan to help decide your case.

This can be done by calling 1-800-600-4441 or writing to us at:

Director of Member Services  
HealthPlus, an Amerigroup Company  
21 Penn Plaza  
360 W. 31st St., Fifth Floor  
New York, NY 10001

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 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, was experimental or investigational, or the out-of-network service was not different from a service that is available in our network and we do not tell you our decision about your action appeal on time, 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 10 days from being told that your coverage request is denied or care is changing
- By the date the change in services is scheduled to occur

If your appeal or your fair hearing results in another coverage 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 we decide to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary
- The service was experimental or investigational or
- The out-of-network service was not different from a service that is available in our network

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 HealthPlus Amerigroup or the state. These reviewers are qualified people approved by New York State.

The service must be in the HealthPlus Amerigroup benefit package, be an experimental treatment, clinical trial or treatment for a rare disease. You do not have to pay for an external appeal. Before you ask for an external appeal:

- You must file an action appeal with the health plan and get the HealthPlus Amerigroup final adverse determination or
- If you have not gotten the service and you ask for a fast-track action appeal with the plan, you may ask for an expedited external appeal at the same time. Your doctor will have to say an expedited external appeal is necessary; or
- You and HealthPlus Amerigroup may agree to skip the HealthPlus Amerigroup appeals process and go directly to an external appeal; or
- You can prove the plan did not follow the rules correctly when processing your action appeal

You have four months after you receive the HealthPlus Amerigroup final adverse determination to ask for an external appeal. If you and HealthPlus Amerigroup agreed to skip the HealthPlus Amerigroup appeals process, you must ask for the external appeal within four months of when you made that agreement.

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 ask for an external appeal. If you choose to file a standard action appeal with the plan and the plan upholds its decision, you will receive a new final adverse determination and have another chance to ask for an external appeal.

Additional appeals to HealthPlus Amerigroup 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 Department of Financial Services within four months from the time HealthPlus Amerigroup gives you the notice of final adverse determination or when you and HealthPlus Amerigroup agreed to waive the HealthPlus Amerigroup 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 Department of Financial Services. You can call Member Services at 1-800-600-4441 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed. Here are some ways to get an application:

- Call the Department of Financial Services at 1-800-400-8882
- Go to the Department of Financial Services website at [www.dfs.ny.gov](http://www.dfs.ny.gov).
- Contact HealthPlus Amerigroup at 1-800-600-4441

Your external appeal will be decided in 30 days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. You and HealthPlus Amerigroup 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 72 hours or less. The reviewer will tell you and HealthPlus Amerigroup 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 HealthPlus Amerigroup 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 if:

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about your staying or leaving HealthPlus Amerigroup
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Family Health Plus 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 coverage of medical care you wanted. You feel the decision limits your Family Health Plus 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 Family Health Plus benefits. You must file a complaint with HealthPlus Amerigroup. If HealthPlus Amerigroup 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.

If you wish to request a fair hearing because HealthPlus Amerigroup denied coverage of medical services, you must make this request within 60 days of receiving the denial letter. You can use one of the following ways to request a fair hearing:

- By phone; call toll free 1-800-342-3334
- By fax, 518-473-6735
- By Internet, [www.otda.state.ny.us/oah/forms.asp](http://www.otda.state.ny.us/oah/forms.asp)
- By mail: New York State Office of Temporary and Disability Assistance  
Office of Administrative Hearings  
Managed Care Hearing Unit  
P.O. Box 22023  
Albany, NY 12201-2023

Remember, you can file a complaint any time with the New York State Department of Health by calling 1-800-206-8125.

## **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:

New York State Department of Health Division of Managed Care  
Bureau of Managed Care Certification and Surveillance  
Corning Tower ESP, Room 1911  
Albany, NY 12237

In New York City, you can also call the New York Medicaid CHOICE HelpLine at 1-800-505-5678. You may also contact your local Department of Social Services with your complaint at any time. You may call the New York Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

## **How to File a Complaint with HealthPlus Amerigroup**

To file by phone, call Member Services at 1-800-600-4441, Monday through Friday, 9:00 a.m. to 6:00 p.m. If you call us after hours, leave a message. We will call you back the next business day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Quality Management Department  
HealthPlus, an Amerigroup Company  
21 Penn Plaza  
360 W. 31st St., Fifth Floor  
New York, NY 10001

You can also fax the complaint to 1-866-495-8716.

### **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 business 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 to tell you the reasons for our decision.
- If 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 seven 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 three business 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 you a letter to 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. If you want to file a complaint appeal, you must do so within 60 business days from when you get our letter with the decision we made about your complaint.

### How to Make a Complaint Appeal

- If you are not satisfied with what we decide, you have at least 60 business 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. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

### What Happens after We Get Your Complaint Appeal

After we get your complaint appeal, we will send you a letter within 15 business 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 business days. If a delay would risk your health, you will get our decision in two business 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 HealthPlus Amerigroup, 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 (if you have questions or concerns about this right, call 1-800-600-4441 and ask for extension 34925 or visit [healthplus.amerigroup.com](http://healthplus.amerigroup.com))
- Be told where, when and how to get the services you need from HealthPlus Amerigroup
- Be told by your Primary Care Provider (PCP) what is wrong, what can be done for you and what will likely be the result in a language you understand
- Get a second opinion about your care
- Give your approval 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, talk about it with your PCP and ask that your medical record be amended or corrected, if needed
- Be sure that your medical record is private and will not be shared with anyone except as required by law or contract or with your approval
- Get a copy of the Notice of Privacy Practices that tells you your rights on Protected Health Information (PHI) and the responsibility of HealthPlus Amerigroup to protect your PHI; this includes the right to know how HealthPlus Amerigroup handles, uses and gives out your PHI
- PHI is defined by HIPAA Privacy Regulations as information that:
  - Identifies you or can be used to identify you
  - Comes from you or has been created or received by a health care provider, a health plan, your employer or a health care clearinghouse
  - Has to do with your physical or mental health condition, providing health care to you, or paying for providing health care to you
- Use the HealthPlus Amerigroup complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you are 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 or if you simply want someone else to speak for you
- Have access to a PCP or a backup PCP 24 hours a day, 365 days a year for urgent care; this information is on your HealthPlus Amerigroup member ID card
- Choose a PCP, choose a new PCP and have privacy during a visit with a health care provider
- Be referred to a non-network provider if HealthPlus Amerigroup does not have an appropriately trained provider in our network
- Get needed medical services within a reasonable amount of time
- Take part in making decisions about your health care with your health care provider
- Receive information on available treatment options and alternatives, regardless of cost or benefit coverage
- Receive considerate, respectful care in a clean, safe environment free of unnecessary restraints
- Choose any of our HealthPlus Amerigroup network specialists after getting a referral from your PCP
- Be referred to specialists who are experienced in treating disabilities, if needed
- Receive information about HealthPlus Amerigroup, its services, policies and procedures, providers, member rights and responsibilities, and any changes made
- Receive information about all benefits and services available from HealthPlus Amerigroup
- Request information about the plan, including clinical review criteria used by the plan in a utilization review decision on a specific disease or condition
- Get a current directory of doctors within the HealthPlus Amerigroup network
- Know how HealthPlus Amerigroup pays health care providers so you know if there are financial incentives or disincentives tied to medical decisions
- Decide ahead of time the kind of care you want if you become sick, injured or seriously ill by making a living will
  - If you are younger than age 18, expect that you will be able to participate in and make decisions about your own and your child's health care if you are married.

- Continue as a member of HealthPlus Amerigroup despite your health status or need for care
- Call our Nurse Helpline 24 hours a day, 7 days a week toll free at 1-800-600-4441
- Call our Member Services department toll free at 1-800-600-4441 from 7:00 a.m. to 7:00 p.m. weekdays, except for state holidays
- Get help from someone who speaks your language
- Make suggestions about the HealthPlus Amerigroup member rights and responsibilities policy

## **Your Responsibilities**

As a member of HealthPlus Amerigroup, you have a responsibility to:

- Find out how your health care plan works
- Carry your HealthPlus Amerigroup ID card at all times; you should report any lost or stolen cards to HealthPlus Amerigroup immediately; you should also contact HealthPlus Amerigroup if information on your ID card is wrong or if you have changes in name, address or marital status
- Show your ID cards to each provider and tell HealthPlus Amerigroup about any health care providers you are currently seeing
- Work with your PCP to guard and improve your health; give HealthPlus Amerigroup and your health care provider the information he or she needs to take care of your medical needs
- Listen to your PCP's advice and ask questions when you are in doubt
- Know and get involved in your health care; you should talk with your health care provider about recommended treatment; you should then follow the plans and instructions for care agreed upon with your provider
- Get information to understand your health problems and consider treatments so you can participate in developing mutually agreed upon treatment goals before services are performed
- 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 same respect you expect
- Tell us if you have problems with any health care staff by calling Member Services
- State your complaint or concern clearly
- Keep your appointments; if you must cancel, call as soon as you can
- Use the emergency room for emergencies; get your covered, nonemergency medical services from HealthPlus Amerigroup providers
- Call your PCP when you need medical care, even if it is after office hours
- Get a referral from your PCP before you go to a hospital or see a specialist (except for emergencies and self-referral services)
- Ask your PCP how to take your medicines the right way
- Be responsible for copays as described in this member handbook
- Be aware that refusing treatment you or your child's provider suggests may have serious consequences for you or your child's health
- Tell your PCP about your health
- Authorize your PCP to get a copy of your old medical records
- Learn and follow HealthPlus Amerigroup health plan membership rules

## 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 he or she knows 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, you should make your wishes known in writing. Your PCP will provide a Do Not Resuscitate (DNR) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

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

## HOW TO REPORT SOMEONE WHO IS MISUSING THE FAMILY HEALTH PLUS PROGRAM

If you know someone who is misusing the Family Health Plus program, you can report him or her. To report PCPs, clinics, hospitals, nursing homes or Family Health Plus enrollees, write or call HealthPlus Amerigroup at:

Corporate Investigations Department  
HealthPlus, an Amerigroup Company  
4425 Corporation Lane  
Virginia Beach, VA 23462  
1-800-600-4441

You can also call the State of New York, Office of the Medicaid Inspector General's Fraud and Abuse Unit at 1-877-873-7283.

## **NOTICE OF PRIVACY PRACTICES**

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.

This notice is in effect April 14, 2003.

### **What Is This Notice?**

This notice tells you:

- How HealthPlus Amerigroup handles your protected health information
- How HealthPlus Amerigroup uses and gives out your protected health information
- What your rights are about your protected health information
- What the HealthPlus Amerigroup responsibilities are in protecting your protected health information

This notice follows what is known as the HIPAA Privacy Regulations. These regulations were given out by the federal government. The federal government requires companies such as HealthPlus Amerigroup to follow the terms of the regulations and of this notice.

NOTE: You may also get a notice of Privacy Practices from the state and other organizations.

### **What Is Protected Health Information?**

The HIPAA Privacy Regulations define Protected Health Information (PHI) as:

- Information that identifies you or can be used to identify you
- Information that either comes from you or has been created or received by a health care provider, a health plan, your employer or a health care clearinghouse
- Information that has to do with your physical or mental health or condition, providing health care to you, or paying for providing health care to you

In this notice, protected health information will be written as PHI.

### **HealthPlus Amerigroup Responsibilities for Your Protected Health Information**

Your and your family's PHI is private. We have rules to help keep it safe and private. These rules are meant to follow state and federal laws. HealthPlus Amerigroup must:

- Protect the privacy of the PHI that we have or keep about you
- Provide you with this notice about how we get and keep PHI about you through:
  - Staff training
  - Secure computer systems and offices
  - Secure disposal of written material that includes PHI
  - Other technical methods
- Provide you with this notice about how we get and keep PHI about you
- Follow the terms of this notice
- Follow state privacy laws that do not conflict with or are stricter than the HIPAA Privacy Regulations

We will not use or give out your PHI without your authorization, except as described in this notice.

### **How Do We Use Your Protected Health Information?**

The sections that follow tell some of the ways we can use and share PHI without your written authorization.

**For payment:** We may use PHI about you so that the treatment services you get may be looked at for payment. For example, a bill that your provider sends us may be paid using information that identifies you, your diagnosis, the procedures or tests, and supplies that were used.

**For health care operations:** We may use PHI about you for health care operations. For example, we may use the information in your record to review the care and results in your case and other cases like it. This information will then be used to improve the quality and success of the health care you get. Another example of this is using information to help enroll you for health care coverage.

We may use PHI about you to help provide coverage for medical treatment or services. For example, information we get from a provider (nurse, doctor or other member of a health care team) will be logged and used to help decide the coverage for the treatment you need. We may also use or share your PHI to:

- Send you information about one of our disease or case management programs
- Send reminder cards that let you know that it is time to make an appointment or get services like EPSDT or Child Health Checkup services
- Answer a customer service request from you
- Make decisions about claims requests and appeals for services you received
- Look into any fraud or abuse cases and make sure required rules are followed

### **Other Uses of Protected Health Information**

**Business associates:** We may contract with business associates that will provide services to HealthPlus Amerigroup using your PHI. Services our business associates may provide include dental services for members, a copy service that makes copies of your record and computer software vendors. They will use your PHI to do the job we have asked them to do. The business associate must sign a contract to agree to protect the privacy of your PHI.

**People involved with your care or payment for your care:** We may make your PHI known to a family member, other relative, close friend or other personal representative that you choose. This will be based on how involved the person is in your care or payment that relates to your care. We may share information with parents or guardians if allowed by law.

**Law enforcement:** We may share PHI if law enforcement officials ask us to. We will share PHI about you as required by law or in response to subpoenas, discovery requests, and other court or legal orders.

**Other covered entities:** We may use or share your PHI to help health care providers that relate to health care treatment, payment or operations. For example, we may share your PHI with a health care provider so that the provider can treat you.

**Public health activities:** We may use or share your PHI for public health activities allowed or required by law. For example, we may use or share information to help prevent or control disease, injury or disability. We also may share information with a public health authority allowed to get reports of child abuse, neglect or domestic violence.

**Health oversight activities:** We may share your PHI with a health oversight agency for activities approved by law, such as audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies include government agencies that look after the health care system; benefit programs including Medicaid, CHIP or Healthy Kids; and other government regulation programs.

**Research:** We may share your PHI with researchers when an institutional review board or privacy board has followed the HIPAA information requirements.

**Coroners, medical examiners, funeral directors and organ donation:** We may share your PHI to identify a deceased person, determine a cause of death or to do other coroner or medical examiner duties allowed by law. We also may share information with funeral directors as allowed by law. We may also share PHI with organizations that handle organ, eye, or tissue donation and transplants.

**To prevent a serious threat to health or safety:** We may share your PHI if we feel it is needed to prevent or reduce a serious and likely threat to the health or safety of a person or the public.

**Military activity and national security:** Under certain conditions, we may share your PHI if you are, or were, in the Armed Forces. This may happen for activities believed necessary by appropriate military command authorities.

**Disclosures to the Secretary of the U.S. Department of Health and Human Services:** We are required to share your PHI with the Secretary of the U.S. Department of Health and Human Services. This happens when the Secretary looks into or decides if we are in compliance with the HIPAA Privacy Regulations.

### **What Are Your Rights Regarding Your Protected Health Information?**

We want you to know your rights about your PHI and your HealthPlus Amerigroup family members' PHI.

### **Right to Get the HealthPlus Amerigroup Notice of Privacy Practices**

We are required to send each HealthPlus Amerigroup head of case or head of household a printed copy of this notice on or before April 14, 2003. After that, each head of case or head of household will get a printed copy of the notice in the New Member Welcome package.

We have the right to change this notice. Once the change happens, it will apply to PHI that we have at the time we make the change and to the PHI we had before we made the change. A new notice that includes the changes and the dates they are in effect will be mailed to you at the address we have for you. The changes to our notice will also be included on our website.

You may ask for a paper copy of the Notice of Privacy Practices at any time. Call Member Services toll free at 1-800-600-4441. If you are deaf or hard of hearing, please call us through our TTY number, 1-800-855-2880.

### **Right to Request a Personal Representative**

You have the right to request a personal representative to act on your behalf, and HealthPlus Amerigroup will treat that person as if the person were you. Unless you apply restrictions, your personal representative will have full access to all of your HealthPlus Amerigroup records.

If you would like someone to act as your personal representative, HealthPlus Amerigroup requires your request in writing. A personal representative form must be completed and mailed back to the HealthPlus Amerigroup Member Privacy Unit. To request a personal representative form, please contact Member Services. We will send you a form to complete. The address and phone number are at the end of this notice.

### **Right to Access**

You have the right to look at and get a copy of your enrollment, claims, payment and case management information on file with HealthPlus Amerigroup. This file of information is called a designated record set. We will provide the first copy to you in any 12-month period without charge.

If you would like a copy of your PHI, you must send a written request to the HealthPlus Amerigroup Member Privacy Unit. The address is at the end of this notice. We will answer your written request in 30 calendar days. We may ask for an extra 30 calendar days to process your request if needed. We will let you know if we need the extra time.

- We do not keep complete copies of your medical records. If you would like a copy of your medical record, contact your doctor or other provider. Follow the doctor or provider's instructions to get a copy. Your doctor or other provider may charge a fee for the cost of copying and/or mailing the record.
- We have the right to keep you from having or seeing all or part of your PHI for certain reasons. For example, if the release of the information could cause harm to you or other persons; or if the information was gathered or created for research, or as part of a civil or criminal proceeding. We will tell you the reason in writing. We will also give you information about how you can file an appeal if you do not agree with us.

### **Right to Amend**

You have the right to ask that information in your health record be changed if you think it is not correct. To ask for a change, send your request in writing to the HealthPlus Amerigroup Member Privacy Unit. We can send you a form to complete. You can also call Member Services to request a form. The address and phone number are at the end of this notice.

- State the reason why you are asking for a change
- If the change you ask for is in your medical record, get in touch with the doctor who wrote the record. The doctor will tell you what you need to do to have the medical record changed

We will answer your request within 30 days of when we receive it. We may ask for an extra 30 days to process your request if needed. We will let you know if we need the extra time.

We may deny the request for change. We will send you a written reason for the denial if:

- The information was not created or entered by HealthPlus Amerigroup
- The information is not kept by HealthPlus Amerigroup
- You are not allowed, by law, to see and copy that information
- The information is already correct and complete

### **Right to an Accounting of Certain Disclosures of Your Protected Health Information**

You have the right to get an accounting of certain disclosures of your PHI. This is a list of times we shared your information when it was not part of payment and health care operations. Most disclosures of your PHI by our business associates or us will be for payment or health care operations.

To ask for a list of disclosures, please send a request in writing to the HealthPlus Amerigroup Member Privacy Unit. We can send you a form to complete. For a copy of the form, contact Member Services. The address and phone number are at the end of this notice. Your request must give a time period that you want to know about. The time period may not be longer than six years and may not include dates before April 14, 2003.

### **Right to Request Restrictions**

You have the right to ask that your PHI not be used or shared. You do not have the right to ask for limits when we share your PHI if we are asked to do so by law enforcement officials, court officials, or state and federal agencies in keeping with the law. We have the right to deny a request for restriction of your PHI.

To ask for a limit on the use of your PHI, send a written request to the HealthPlus Amerigroup Member Privacy Unit. We can send you a form to fill out. You can contact Member Services for a copy of the form. The address and phone number are at the end of this notice. The request should include:

- The information you want to limit and why you want to restrict access
- Whether you want to limit when the information is used, when the information is given out, or both
- The person or persons that you want the limits to apply to

We will look at your request and decide if we will allow or deny the request within 30 days. If we deny the request, we will send you a letter and tell you why.

### **Right to Cancel a Privacy Authorization for the Use or Disclosure of Protected Health Information**

We must have your written permission (authorization) to use or give out your PHI for any reason other than payment and health care operations or other uses and disclosures listed under Other Uses of Protected Health Information. If we need your authorization, we will send you an authorization form explaining the use for that information. You can cancel your authorization at any time by following the instructions below.

Send your request in writing to the HealthPlus Amerigroup Member Privacy Unit. We can send you a form to complete. You can contact Member Services for a copy of the form. The address and phone number are at the end of this notice. This cancellation will only apply to requests to use and share information asked for after we get your cancellation request.

**Right to Request Confidential Communications**

You have the right to ask that we communicate with you about your PHI in a certain way or in a certain location. For example, you may ask that we send mail to an address that is different from your home address. Requests to change how we communicate with you should be submitted in writing to the HealthPlus Amerigroup Member Privacy Unit. We can send you a form to complete. For a copy of the form, contact Member Services. The address and phone number are at the end of this notice. Your request should state how and where you want us to contact you.

**What Should You Do If You Have a Complaint about the Way That Your Protected Health Information Is Handled by HealthPlus Amerigroup or Our Business Associates?**

If you believe that your privacy rights have been violated, you may file a complaint with HealthPlus Amerigroup or with the Secretary of Health and Human Services.

To file a complaint with HealthPlus Amerigroup or to appeal a decision about your PHI, send a written request to the HealthPlus Amerigroup Member Privacy Unit or call Member Services. The address and phone number are at the end of this notice. To file a complaint with the Secretary of Health and Human Services, send your written request to:

Office for Civil Rights  
U.S. Department of Health and Human Services  
26 Federal Plaza, Suite 3312  
New York, NY 10278

You will not lose your HealthPlus Amerigroup membership or health care benefits if you file a complaint. Even if you file a complaint, you will still get health care coverage from HealthPlus Amerigroup as long as you are a member.

**Where Should You Call or Send Requests or Questions about Your Protected Health Information?**

You may call us toll free at 1-800-600-4441. Or you may send questions or requests, such as the examples listed in this notice, to the address below:

Member Privacy Unit  
HealthPlus, an Amerigroup Company  
4425 Corporation Lane  
Virginia Beach, VA 23462

Send your request to this address so that we can process it timely. Requests sent to persons, offices or addresses other than the address listed above might be delayed.

If you are deaf or hard of hearing, please call us through our TTY number at 1-800-855-2880.

# IMPORTANT PHONE NUMBERS

Your PCP ..... \_\_\_\_\_  
(write number above)

## HealthPlus, an Amerigroup Company

21 Penn Plaza  
360 W. 31st St., Fifth Floor  
New York, NY 10001

Member Services..... 1-800-600-4441

HealthPlus Amerigroup TTY/TDD .....1-800-855-2880

24-hour Nurse HelpLine .....1-800-600-4441

Your nearest Emergency Room ..... \_\_\_\_\_  
(write number above)

New York State Department of Health (Complaints) ..... 1-800-206-8125

Human Resources Administration (HRA) ..... 718-557-1399

Putnam County Department of Social Services (LDSS) .....1-845-225-7040

New York City Department of Social Services (LDSS) ..... 1-877-472-8411

### New York State Managed Care HelpLine:

- New York Medicaid CHOICE.....1-800-505-5678
- Outside New York City..... 1-888-367-6557
- New York Medicaid CHOICE HelpLine for SSI Members..... 1-800-774-4241

AT&T Relay Service for those who are deaf or hard of hearing .....1-800-855-2880

Local Pharmacy ..... \_\_\_\_\_  
(write number above)

### Other Health Providers:

\_\_\_\_\_  
\_\_\_\_\_