

# Health Plus

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## Member Handbook

New York

Medicaid

# **NEW YORK STATE MEDICAID MANAGED CARE MEMBER HANDBOOK**

**Revised For January 2014**

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# WELCOME TO THE HEALTHPLUS AMERIGROUP MEDICAID MANAGED CARE PROGRAM

We are glad that you chose HealthPlus, an Amerigroup Company. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at 1-800-600-4441.

## How managed care works

### The plan, our providers and you

No doubt you have seen or heard about the changes in health care. Many consumers now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of managed care health plans. In all counties, people with Medicaid must join a health care plan unless excluded or exempt.

HealthPlus Amerigroup has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call 1-800-600-4441 to get a copy.

When you join HealthPlus Amerigroup, one of our providers will take 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 it. Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message with 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 10 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 you when you join a managed care plan. It will 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 several pages 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 check it out a bit at a time.

When you have a question, check this handbook or call our Member Services unit. You can also call the managed care staff at your local Department of Social Services (LDSS).

You can find the phone number for your LDSS on the last page of this handbook. If you live in New York City, Nassau County or Putnam County, 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 Monday through Friday from 9 a.m. to 6 p.m. Call 1-800-600-4441.

If you are deaf or hard of hearing, call the HealthPlus Amerigroup AT&T Relay Service at 1-800-855-2880.

If you need help or health care advice at other times, call our Nurse HelpLine at 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 anytime you have a question.** You may call us to choose or change your primary care provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.

If you are or become pregnant, your child will become part of HealthPlus Amerigroup on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call your local Department of Social Services and us right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.

We offer **free 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 is best for you.

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

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

- TTY 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 name and phone number on it. It will also have your client identification number (CIN). If anything is wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that HealthPlus Amerigroup does not cover. This includes outpatient chemical dependency services at a clinic.

## PART 1: FIRST THINGS YOU SHOULD KNOW

### How to choose your primary care provider

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. **If you have not chosen a PCP for you and your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.

With this handbook, you should have a provider directory, 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:

- Whom you have seen before
- Who understands your health problems
- Who is taking new patients
- Who can serve you in your language
- Who is easy to get to

You may also want to know your doctor's professional qualifications, specialty, medical school attended or where the provider completed his or her residency (training) or if he or she is board-certified in a specific area of medicine. You can find out all this information by visiting [www.nydoctorprofile.com](http://www.nydoctorprofile.com).

Women can also choose one of our contracted obstetrician or gynecologist (OB-GYN) doctors to deal with women's health issues. Women do not need a PCP referral to see a HealthPlus Amerigroup contracted OB-GYN doctor. They can have routine checkups (twice a year), follow-up care if there is a problem and regular care during pregnancy. If a woman has a serious problem, like a lump in her breast or a positive Pap smear, she can see a participating OB-GYN specialist without a referral.

We also contract with Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a PCP at one of the FQHCs that we work with, listed below. Just call Member Services at 1-800-600-4441 for help.



## HealthPlus Amerigroup Federally Qualified Health Centers

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

690 Amsterdam Ave.  
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 St.  
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 St.  
Brooklyn, NY 11217  
718-596-9800

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

592 Rockaway Ave.  
Brooklyn, NY 11212  
718-345-5000

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

592 Rockaway Ave.  
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 Ave.  
Brooklyn, NY 11208  
718-277-8303

### **Lutheran Medical Center**

150 55th St.  
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 St.  
Brooklyn, NY 11211  
718-852-0803

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

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

### **Parkchester Family Practice**

1597 Unionport Road  
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 E. 151 St.  
Bronx, NY 10455  
718-402-2800

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

**CHN – CABS Center**  
94-98 Manhattan Ave.  
Brooklyn, NY 11206  
718-388-0390

**CHN – Caribbean House Center**  
1167 Nostrand Ave.  
Brooklyn, NY 11225  
718-778-0198

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

**CHN – Downtown Health Center**  
150 Essex St.  
New York NY 10002  
212-477-1120

**CHN – Helen B Atkinson Center**  
81 W. 115th St.  
New York, NY 10026  
212-426-0088

**CHN – Queens Center**  
97-04 Sutphin Blvd.  
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 Ave.  
Jamaica, NY 11435  
718-298-5100

**Refuah Health Center – Spring Valley**  
**Location**  
728 N. Main St.  
Spring Valley, NY 10977  
845-354-9300

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

**Refuah Health Center – South Fallsburg**  
**Location**  
South Fallsburg Family Medical  
36 Laurel Ave.  
South Fallsburg, NY 12779  
845-354-9300

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

**Ryan/Chelsea-Clinton Community Health Center**  
645 10th Ave.  
New York, NY 10036  
212-265-4500

**Ryan-Nena Community Health Center**  
279 E. Third St.  
New York, NY 10009  
212-477-8500

**Settlement Health & Medical Service**  
212 E. 106 St.  
New York, NY 10029  
212-360-2600

**Sidney Hillman Family Practice**  
16 E. 16th St.  
(Between Fifth Ave. and W. Union Square)  
New York, NY 10003  
212-924-7744

**Sunset Park Family Health Center**  
150 55th St.  
Brooklyn, NY 11220  
718-630-7095

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

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

**East 13th Street Family Practice**

113 E. 13th St.  
New York, NY 10003  
212-253-1830

**EHCHS Inc. Boriken Neighborhood Health Center**

2253 Third Ave., Third 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

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

16 E. 16th St.  
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

**Sunset Terrace Family Health Center**

514 49th St.  
Brooklyn, NY 11220  
718-431-2600

**Urban Health Plan – Bella Vista Health Center**

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

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

1065 Southern Blvd.  
Bronx, NY 10459  
718-589-2440

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

1515 Southern Blvd.  
Bronx, NY 10460  
718-589-1600

**Urban Horizons Family Practice**

50 E. 168th St.  
Bronx, NY 10452  
718-293-3961

**Walton Family Health Center**

1894 Walton Ave.  
Bronx, NY 10453  
718-583-3060

**William F. Ryan Community Health Center**

110 W. 97th St.  
New York, NY 10025  
212-316-7906

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

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 through post-partum 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.

In both cases, however, your doctor must agree to work 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 the Plan 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 keep you well, give you advice when you need it, and refer you 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 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 either/or:
  - 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

Medical necessity is based on the right coverage, the level of care and service, and care that is consistent with health care practices accepted by professionally recognized health care organizations or governmental agencies and with the diagnosis of the condition. Amerigroup does not offer financial incentives or disincentives to the medical team who makes these decisions.

The HealthPlus Amerigroup medical director and network doctors review new medical advances. They do this to decide if these advances and new treatments should be covered benefits. They also review medical studies and see if the government has agreed that the treatment is safe and effective. The new advances must show that results are as good as or better than treatments currently covered in the benefits.

- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know. If you can, prepare for your first appointment. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.
- If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)
- **Use the following list as an appointment guide for our limits on how long you may have to wait after your request for an appointment:**
  - Adult baseline and routine physicals: within 12 weeks
  - Urgent care: within 24 hours
  - Nonurgent sick visits: within three days
  - Routine, preventive care: within four weeks
  - First prenatal visit: within three weeks during the first trimester (two weeks during the second trimester, one week during third trimester)
  - First newborn visit: within two weeks of hospital discharge
  - First family planning visit: within two weeks
  - Follow-up visit after mental health/substance abuse ER or inpatient visit: five days
  - Nonurgent mental health or substance abuse visit: two weeks

## How to get specialty care and referrals

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

If you are having trouble getting a referral you think you need, contact Member Services at 1-800-600-4441.

If you need to see a specialist outside HealthPlus Amerigroup because we do not have a HealthPlus Amerigroup 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 HealthPlus Amerigroup. 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 **Service authorization request** section for details.

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 **Service authorization appeals (Action appeals)** section for details.

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

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.

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

- Your specialist to act as your PCP
- A referral to a specialty care center that deals with the treatment of your problem

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

## **Get these services from HealthPlus Amerigroup without a referral**

### **Women's services**

You do not need a referral from your primary care provider (PCP) to see one of our providers if any of the following applies to you:

- You are pregnant
- 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
- Elective abortions in New York City
- A medically necessary abortion

During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam and a pelvic exam.

**You do not need a referral or a script from your PCP to get these services.** In fact, you can choose where to get these services. You can use your HealthPlus Amerigroup ID card to see one of the HealthPlus Amerigroup family planning providers. Check the plan's provider directory or call Member Services for help in finding a provider. Or you can use your Medicaid card if you want to go to a doctor or clinic outside HealthPlus Amerigroup. Ask your PCP or call Member Services at 1-800-600-4441 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

### **HIV 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 one of our family planning providers.

If you'd rather not see one of the HealthPlus Amerigroup providers, you can use your Medicaid card to see a family planning provider outside HealthPlus Amerigroup. For help in finding either a plan provider or a Medicaid provider for family planning services, call Member Services at 1-800-600-4441.

If you want HIV testing and counseling, but not as part of a family planning service, your PCP can provide or 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**

The covered benefits include the needed services of an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You just choose one of our participating providers. New eyeglasses (with Medicaid approved frames) are usually provided once every two years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

### **Mental health/Chemical dependence (including alcohol and substance abuse)**

You may go for one mental health assessment without a referral in any 12-month period. You must use a HealthPlus Amerigroup provider, but you do not need an OK from your PCP. You may also go for one chemical dependence assessment, without a referral in any 12-month period. You must use a plan provider or a chemical dependency clinic. If you need more visits, your PCP will help you get a referral. If you want a chemical dependence assessment for any alcohol and/or substance abuse outpatient treatment services, except outpatient detoxification services, you must use your Medicaid benefit card to go to a chemical dependency clinic.

## Emergencies

You are always covered for emergencies. An emergency means a medical or behavioral condition that comes on all of a sudden and has pain or other symptoms. This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.

Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing, convulsions or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever or vomiting

Examples of **nonemergencies** are:

- Colds
- Sore throat
- Upset stomach
- Minor cuts and bruises
- Sprained muscles

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

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

**If you're not sure, call your PCP or HealthPlus Amerigroup.** Tell the person you speak with what is happening. Your PCP or Member Services representative will tell you either/or:

- What to do at home
- To come to the PCP's office
- 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, you do not need prior approval for emergency services.**

- Use the emergency room only if you have an emergency.
- The emergency room should NOT be used for problems like the flu, sore throats or ear infections.
- If you have questions, call your PCP 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 getting medical advice, you can call the HealthPlus Amerigroup Nurse HelpLine anytime 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:

- A child with an earache who wakes up in the middle of the night and won't stop crying
- 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 primary care provider (PCP) any time, day or night. If you cannot reach your PCP, call us at 1-800-600-4441. Tell the person who answers what is happening. They will tell you what to do.

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

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

## **We want to keep you healthy**

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

- Classes for you and your family
- Stop-smoking classes
- Prenatal care and nutrition
- Grief/loss support
- Breastfeeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training

Call Member Services at 1-800-600-4441 to find out more and get a list of upcoming classes.

## **Case management services**

Amerigroup has a case management program that provides education and support to help you make informed health care choices. Our goal is to help you get the care you need, when you need it. A team of licensed nurses and social workers called Care Managers can assist you by providing you with education about your condition, assisting with provider appointments and working with you to develop a plan of care to stay as healthy as possible. You or your representative can request case management services by calling Member Services at 1-800-600-4441.

### **Disease Management Centralized Care Unit program**

HealthPlus Amerigroup has a team of licensed nurses and social workers called Care Managers who help educate you about your condition and help you learn how to manage your care. Your PCP and our team of care managers will assist you with your health care needs. This is a voluntary program, and you do not need to participate. Care managers can also provide support over the phone for members with certain health conditions.

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

If you have questions or would like to know more about our disease management program, 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 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 the noncovered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

### **Benefits**

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. HealthPlus Amerigroup will provide or arrange for most services that you will need. You can get a few services, however, without going through your primary care provider (PCP). These include emergency care, family planning, HIV testing and counseling, and specific self-referral services, including those you can get from within the plan and some that you can choose to go to any Medicaid provider of the service. Please call our Member Services department at 1-800-600-4441 if you have any questions or need help with any of the services below.

### **Balance billing**

The provider is not allowed to bill or request any payment from the Medicaid managed care member. The only circumstance in which a provider may bill a Medicaid managed care member is a nonemergency situation in which the provider informs the member before providing the service that the service is not covered under the member's managed care plan and does not qualify for Medicaid reimbursement. The provider must also inform the member that he or she will be responsible for payment. In this situation, we suggest the provider get the patient's signed acknowledgement of their payment liability. As a member, if you receive a bill and have questions, please contact our Member Services department at 1-800-600-4441 for additional assistance.

### **Services covered by HealthPlus Amerigroup**

**You must get these services from the providers who are in HealthPlus Amerigroup.**

All services must be medically necessary and provided or referred by your primary care provider (PCP).

#### **Regular medical care**

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

#### **Preventive care**

- Well-baby care
- Well-child care
- Regular checkups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- Smoking-cessation counseling (Enrollees are eligible for six sessions in a calendar year.)

Medicaid Managed Care Member Handbook

Member Services Department 1-800-600-4441 (TTY 1-800-855-2880)

**Maternity care**

- Pregnancy care
- Doctors/midwife and hospital services
- Newborn nursery care

**Home health care**

(Must be medically needed and arranged by HealthPlus Amerigroup)

- One medically necessary postpartum home health visit, additional visits as medically necessary for high-risk women
- At least two visits to high-risk infants (newborns)
- Other home health care visits as needed and ordered by your PCP/specialist

**Personal care/Home attendant/Consumer directed personal assistance services (CDPAS)**

(Must be medically needed and arranged by HealthPlus Amerigroup)

- Personal care/Home attendant – Provide some or total assistance with personal hygiene, dressing and feeding and assist in preparing meals and housekeeping.
- CDPAS – Provide some or total assistance with personal hygiene, dressing and feeding, meals and housekeeping, and home health aide and nursing tasks. This is provided by an aide chosen and directed by you. If you want more information, contact HealthPlus Amerigroup at 1-800-600-4441.

**Personal emergency response system (PERS)**

This is a piece of equipment you wear to get help if you have an emergency. In order to qualify and receive this service, you must be receiving personal care/home attendant or CDPAS services.

**Adult day health care services**

(Must be recommended by your PCP)

- Provides some or all of the following: health education, nutrition, interdisciplinary care planning, nursing and social services, assistance and supervision with the activities of daily living, restorative, rehabilitative and maintenance services, planned therapeutic or recreational activities, pharmaceutical services, as well as referrals for necessary dental services and sub-specialty care.

**AIDS adult day health care services**

(Must be recommended by your PCP)

- Provides general medical and nursing care, substance abuse supportive services, mental health supportive services, individual and group nutritional services, as well as structured socialization, recreational and wellness/health promotion activities.

**Directly observed therapy for tuberculosis disease**

- Provides observation and dispensing of medication, assessment of any adverse reactions to medications and case follow-up.

## Hospice benefit

(HealthPlus Amerigroup will provide the hospice benefit. This service must be medically needed and arranged by HealthPlus Amerigroup.)

- Hospice care provides noncurative medical and support services for members certified by a physician to be terminally ill with a life expectancy of one year or less. Hospice may be provided in your home or in an inpatient setting.
- Hospice programs provide patients and their families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses experienced during the final stages of illness and during dying and bereavement.
- For children under age 21 who are receiving hospice services, medically necessary curative services are covered, in addition to palliative care.

If you have any questions about this benefit, you can call our Member Services department toll free at 1-800-600-4441.

## 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, filings, 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 **primary care dentist (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) Monday through Friday from 8 a.m. to 6 p.m. Member Services 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.

## Orthodontic care

HealthPlus Amerigroup will cover braces for children up to age 21 who have a severe problem with their teeth, such as can't chew food due to severely crooked teeth, cleft palette or cleft lip.

### Vision care

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary (Artificial eyes are covered as ordered by a plan provider.)
- Eye exams, generally every two years, unless medically needed more often
- Glasses (new pair of Medicaid approved frames every two years, or more often if medically needed)
- Low vision exam and vision aids ordered by your doctor
- Specialist referrals for eye diseases or defects

### Pharmacy

- Prescription drugs
- Over-the-counter (OTC) medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Emergency contraception (six per calendar year)
- Medical and surgical supplies

A pharmacy copay may be required for some people for some medications and pharmacy items. There are no copays for the following consumers/services:

- Consumers younger than 21 years old
- Consumers who are pregnant; pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends
- Consumers in an OMH or OPWDD Home and Community-Based Services (HCBS) Waiver program
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI)
- Family planning drugs and supplies like birth control pills and condoms
- Drugs to treat mental illness (psychotropic) and tuberculosis

Prescription item	Copay amount	Copay details
Brand-name	\$3/\$1	<ul style="list-style-type: none"><li>• One copay charge for each new prescription drug and each refill</li><li>• No copay for drugs to treat mental illness (psychotropic) and tuberculosis</li></ul>
Generic prescription drugs	\$1	
Over-the counter medications (e.g., for smoking cessation and diabetes)	\$0.50 per medication	

There is a copayment for each new prescription *and* each refill. If you are required to pay a copay, you are responsible for a maximum of \$200 per calendar year. If you transferred plans during the calendar year, keep your receipts as proof of your copayments or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan.

Certain medications may require that your doctor get prior authorization 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).

### **Hospital care**

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

### **Emergency care**

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the emergency room, in an inpatient hospital room, or in another setting. This is called **poststabilization services**.
- For more about emergency services, see page 12.

### **Mental health/Chemical dependence (including alcohol and substance abuse)**

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

### **Specialty care**

Includes the services of other practitioners, including

- Occupational, physical and speech therapists – Limited to 20 visits per therapy per calendar year, except for children under age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury
- Audiologists
- Midwives
- Cardiac rehabilitation
- Podiatrists, if you are diabetic

### **Residential health care facility care (Nursing home)**

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

### **Transportation\***

If you live in Nassau County, you or your provider should call LogistiCare at 1-866-481-9488 (TTY 1-866-288-3133). If possible, you or your provider should call LogistiCare at least three days before your medical appointment and provide your HealthPlus Amerigroup ID number (i.e., AB12345C), appointment date and time, address where you are going, and doctor you are seeing.

Routine and nonemergency medical transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

If you require an attendant to go with you to your doctor's appointment or if your child is the member of the plan, transportation is also covered for the attendant or parent/guardian.

**How you get emergency transportation will not change. If you have an emergency and you need an ambulance, you must call 911.**

If you have questions about transportation, please call Member Services at 1-800-600-4441.

\*Starting January 1, 2013, emergency and nonemergency transportation will be covered by regular Medicaid in New York City. See page 22: **Benefits using your Medicaid card only.**

### **Other covered services**

- Durable medical equipment (DME)/Hearing aids/Prosthetics/Orthotics
- Court ordered services
- Case management
- Help getting social support services
- FQHC
- Family planning
- Services of a podiatrist for children under 21 years old



## **Benefits you can get from HealthPlus Amerigroup or with your Medicaid card**

For some services, you can choose where to get the care. You can get these services by using your HealthPlus Amerigroup membership card. You can also go to providers who will take your Medicaid benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at 1-800-600-4441.

### **Family planning**

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

### **HIV testing and counseling**

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

### **Tuberculosis 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.

## **Benefits using your Medicaid card only**

There are some services HealthPlus Amerigroup does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid benefit card.

### **Outpatient chemical dependency**

You can go to any chemical dependence clinic that provides outpatient chemical dependency.

### **Transportation**

If you live in Putnam County, to get nonemergency or routine transportation, you or your provider should call Medical Answering Services (MAS) at 1-855-360-3547. If possible, you or your provider should call MAS at least three days before your medical appointment and provide:

- Your Medicaid ID card number
- Your appointment date and time
- The address where you are going
- The doctor you are seeing

Routine and nonemergency transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

**How you get emergency transportation will not change. If you have an emergency and need an ambulance, you must call 911.**

If you live in New York City, starting January 1, 2013, emergency and nonemergency transportation will be covered by regular Medicaid. To get nonemergency transportation, you or your provider should call LogistiCare at 1-877-564-5922. If possible, you or your provider should call LogistiCare at least three days before your medical appointment and provide your Medicaid identification number (i.e., AB12345C), appointment date and time, address where you are going, and doctor you are seeing.

Nonemergency medical transportation includes personal vehicle, bus, taxi, ambulette and public transportation.

**How you get emergency transportation will not change. If you have an emergency and need an ambulance, you must call 911.**

### **Mental health**

- Intensive psychiatric rehab treatment
- Day treatment
- Intensive case management
- Partial hospital care
- Rehab services to those in community homes or in family-based treatment
- Clinic services for children with a diagnosis of serious emotional disturbance (SED) at mental health clinics certified by the State Office of Mental Health
- Continuing day treatment
- All covered mental health services for people who receive SSI or who are certified blind or disabled are available by using the Medicaid benefit card.

### **Mental retardation and developmental disabilities**

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community-Based Services (HCBS) waiver program
- Medical model (care-at-home) waiver services

### **Alcohol and substance abuse services**

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

### **Other Medicaid services**

- Preschool and school services programs (early intervention)
- Early start programs

### **Services not covered**

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

- Cosmetic surgery if not medically needed
- Services of a podiatrist (for those 21 years and older unless you are a diabetic)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of HealthPlus Amerigroup, unless it is a provider you are allowed to see as described elsewhere in this handbook or HealthPlus Amerigroup or your PCP send you to that provider
- Services for which you need a referral (approval) in advance and you did not get it

You may have to pay for any service that your PCP does not approve. Also, if before you get a service, you agree to be a private pay 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.

## 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:

- Some ambulatory surgery
- Chemotherapy
- Dialysis
- Durable medical equipment
- Growth hormone evaluation and therapy
- Digital hearing aids
- Home care
- Hyperbaric oxygen therapy
- Inpatient services
- Lithotripsy
- Non-emergent fixed wing transportation
- Obstetrical services (except family planning services)
- Oxygen equipment – respiratory therapy
- Prosthetics and orthotics
- Some drugs
- Transplant evaluation

Your provider 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, your doctor needs to call the HealthPlus Amerigroup Medical Management department at 1-800-450-8753. If necessary, your doctor can call for an approval after-hours and on weekends by calling this number. If you have any questions, call the Member Services department Monday through Friday 9 a.m. to 6 p.m. Eastern time at 1-800-600-4441. We have translation services for you if you do not speak English. If you are deaf or hard of hearing, please call the toll-free AT&T Relay Service number at 1-800-855-2880. We accept collect calls.

### What happens after we get your service authorization request?

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

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. Doctors and nurses on the review team do not receive financial incentives for denying service authorization requests. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request we will review it under a **standard** or **fast-track** process. You or your doctor can ask for a fast-track review if it is believed that a delay will cause serious harm to your health. If your request for a fast-track review is denied, we will tell you and your case will be handled under the standard review process. 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 business days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast-track review:** We will make a decision and you will hear from us within three business days. We will tell you by the third business day if we need more information.

#### Time frames for concurrent review requests

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

However, if you are in or have just left the hospital, and you ask for home health care on a Friday or 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 business days after we received your request. We will tell you by the third business day if we need more information.

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

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

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-600-4441 or writing to us at:

Health Care Management Services  
HealthPlus, an Amerigroup Company  
9 Pine St., 14th Floor  
New York, NY 10005

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

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

### **Other decisions about your care**

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

### Time frames for notice of other actions

In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.

If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

## 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.

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

We expect nurses and doctors making decisions on coverage of care and services to:

- Make decisions based in the right care and services and the benefit coverage
- Understand that we do not reward providers or others if they deny coverage of care or services
- Make sure the money paid to decision makers does not end in the misuse of needed health care

## You can help with plan policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-600-4441 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
- We will tell you in writing...
  - How HealthPlus Amerigroup checks on the quality of the care given to our members
  - Which hospitals our health providers work with
  - The guidelines we use to review conditions or diseases that are covered by HealthPlus Amerigroup

- The qualifications needed and how health care providers can apply to be part of HealthPlus Amerigroup
- If you ask us, we will tell you:
  - Whether our contracts or subcontracts include physician incentive plans that affect the use of referral services
  - Information on the type of incentive arrangements used
  - Whether stop loss protection is provided for physicians and physicians groups
  - Information about how our company is organized and how it works

## Keep us informed

### Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number.
- You have a change in Medicaid eligibility.
- You are pregnant.
- You give birth.
- There is a change in insurance for you or your children.

## Disenrollment and transfers

### 1. If you want to leave HealthPlus Amerigroup

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

Some examples of “good cause” include:

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

### To change plans:

You may be able to transfer to another plan over the phone. Unless you are excluded or exempt from managed care, you will have to choose another health plan.

Call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.



It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. HealthPlus Amerigroup will provide the care you need until then.

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 New York Medicaid Choice.

## **2. You could become ineligible for Medicaid Managed Care**

You or your child may have to leave HealthPlus Amerigroup if you or the child:

- Moves out of the county or service area
- Changes to another managed care plan
- Joins an HMO or other insurance plan through work
- Go to prison
- Become a permanent resident of a nursing home

Your child may have to leave HealthPlus Amerigroup or \*change plans if he or she:

- Joins a Physically Handicapped Children's Program, or
- Is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services, including all children in foster care in New York City, or
- \*Is placed in foster care by the Local Department of Social Services in an area that is not served by your child's current plan.

## **3. We can ask you to leave HealthPlus Amerigroup**

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

- Refuse to work with your PCP in regard to your care
- Don't keep appointments
- Go to the emergency room for nonemergency care
- Don't follow the HealthPlus Amerigroup rules
- Do not fill out forms honestly or do not give true information (commit fraud)
- Cause abuse or harm to plan members, providers or staff
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems

## **Action appeals**

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

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

### **Your provider can ask for reconsideration**

If we made a decision 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 business day.

### **You can file an action appeal**

If you are not satisfied with an action we took or what we decide about your service authorization request, you have 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 action appeal will be reviewed under the fast-track process if one of the following applies:**

- You or your doctor asks to have your action appeal reviewed under the fast-track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast-track is denied we will tell you and your action appeal will be reviewed under the standard process.
- 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.
- Your request was denied when you asked for home health care after you were in the hospital.

Fast-track action appeals can be made by phone and do not have to be followed up in writing.

### **What happens after we get your action appeal?**

Within 15 days, we will send you a letter to let you know we are working on your action appeal.

Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

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 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 the following:

- 1) A written statement that the service you asked for is different from the service we have in our network
- 2) 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, or 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 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 action 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 action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-800-600-4441 or writing to us at:

Quality Management Department  
HealthPlus, an Amerigroup Company  
9 Pine St., 14th Floor  
New York, NY 10005

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

If your original denial was because we said the service was not medically necessary; or the service 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 action appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for a fair hearing:

- Within 10 days from being told that your request is denied or care is changing or
- By the date the change in services is scheduled to occur

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

### **External appeals**

If the plan decides to deny coverage for a medical service you and your doctor asked for because:

- The service was not medically necessary
- The service was experimental or investigational
- 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 the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, 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 plan and get the plan's final adverse determination
- 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
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal
- You can prove the plan did not follow the rules correctly when processing your action appeal

You have four months after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 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 your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the New York State Department of Financial Services within four months from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

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

To ask for an external appeal, fill out an application and send it to the 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 the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan

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 the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

## **Fair hearings**

In some cases you may ask for a fair hearing from New York State 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 Medicaid benefits or that we did not make the decision in a reasonable amount of time.

- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Medicaid benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint 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.

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.ny.gov/oahforms/erequestform.aspx](http://www.otda.ny.gov/oahforms/erequestform.aspx)
- By mail:  
NYS 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 complain anytime to the New York State Department of Health by calling 1-800-206-8125.

## **Complaint process**

### **Complaints**

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

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

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

NYS Department of Health, Division of Managed Care  
Bureau of Managed Care Certification and Surveillance  
ESP Corning Tower Room 2019  
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at (1-800-342-3736) if your complaint involves a billing problem.

### **How to file a complaint with the plan**

To file by phone, call Member Services at 1-800-600-4441 Monday through Friday from 9 a.m. to 6 p.m. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you. You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Complaint Specialist  
Quality Management Department  
HealthPlus, an Amerigroup Company  
9 Pine St., 14th Floor  
New York, NY 10005

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 and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 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 a letter and let you know.

## **Complaint appeals**

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

### **How to make a complaint appeal**

If you are not satisfied with what we decide, you have 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 and 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 us
- 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 our responsibility to protect your PHI; this includes the right to know how we handle, use and give 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 our 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 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 we do 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 network specialists after getting a referral from your PCP
- Be referred to specialists who are experienced in treating disabilities, if needed
- Receive information about us, our services, policies and procedures, providers, member rights and responsibilities, and any changes made
- Receive information about all benefits and services available from us
- 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 our network
- Know how we pay 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 and married, expect that you will be able to participate in and make decisions about your own and/or your child's health care.
- Continue as a member of HealthPlus Amerigroup and our affiliated companies 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 a.m. to 7 p.m. weekdays, except for state holidays
- Get help from someone who speaks your language
- Make suggestions about our member rights and responsibilities policy

### **Your responsibilities**

As a member of HealthPlus Amerigroup, you agree to:

- Find out how your health care plan works.
- Carry your member ID card at all times. You should report any lost or stolen cards to us immediately. You should also contact us 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 us about any health care providers you are currently seeing.
- Work with your PCP to guard and improve your health. Give us 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 our 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 the 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 our health plan membership rules stated in this handbook.

### **Quality Management program**

The Quality Management program's objective is to monitor and evaluate the care and service provided to our members. The program is developed keeping the needs of the population served as our number one objective. Re-evaluation of the program occurs on an annual basis. Members have opportunities to make recommendations regarding activities in areas that may need improvement.

The Quality Management program goals and outcomes are available to members upon request. To request a copy of the HealthPlus Amerigroup Quality Management Evaluation, call 212-563-5570 and ask for the Quality Management department.

## 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 primary care provider (PCP), your family or others close to you so they will know what you want.
- Third, it is best if you **put your thoughts in writing**. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

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

**CPR and DNR** – You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a 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.

## HIPAA NOTICE OF PRIVACY PRACTICES

The original effective date of this notice was April 14, 2003. The most recent revision date is indicated in the footer of this notice.

*Please read this notice carefully.*

**This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells what rights you have to see and change your information.**

Information about your health and money is private. The law says we must keep this kind of information, called PHI safe for our members. That means if you're a member right now or if you used to be.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get PHI from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- On a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

### **When is it OK for us to use and share your PHI?**

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them

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.

- **For health care business reasons**
  - To help with audits, fraud and abuse programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care if you can't speak for yourself and it's best for you**

We must get your OK in writing before we use or share your PHI for anything but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

**Other ways we can – or the law says we have to – use your PHI:**

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to Worker's Compensation if you get sick or hurt at work

**What are your rights?**

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in another way. We can do this if sending it to the address we have for you may put you in danger.

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.

- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

### **What do we have to do?**

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to another address or send it in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI hasn't been kept private.

### **What if you have questions?**

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-800-600-4441**. If you're deaf or hard of hearing, call the AT&T Relay Service at **1-800-855-2880**.

### **What if you have a complaint?**

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

### **Write to or call the U.S. Department of Health and Human Services:**

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

We reserve the right to change this notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at **[www.myamerigroup.com](http://www.myamerigroup.com)**.

As we told you in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws if they say we need to do more than the Federal HIPAA Privacy Rule. This notice tells you about your rights and what the state laws say we have to do.

### **Your personal information**

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.



## IMPORTANT PHONE NUMBERS

Your primary care provider (PCP) ..... \_\_\_\_\_  
(write number above)

### HealthPlus, an Amerigroup Company

9 Pine St., 14th Floor  
New York, NY 10005

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

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:

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

For more information about Medicaid Managed Care, call New York Medicaid Choice at 1-800-505-5678.  
For more information about Child Health Plus and Medicaid, call New York Health Options at 1-800-541-2831. To learn more about signing up for a health plan through NY State of Health, visit [nystateofhealth.ny.gov](http://nystateofhealth.ny.gov) or call 1-855-355-5777.