Health Plus
Amerigroup
Real Solutions

Real

Solutions

Member Handbook
New York

1-800-600-4441 ■ healthplus.amerigroup.com
NEW YORK STATE
FAMILY HEALTH PLUS
MEMBER HANDBOOK

Revised for January 2014
Services not covered........................................................................................................................................... 20
Transportation services ........................................................................................................................................ 21

SERVICES AUTHORIZATION AND ACTIONS ................................................................................................. 22
Prior authorization and time frames .................................................................................................................. 22
Other decisions about your care ....................................................................................................................... 24
How our providers are paid .............................................................................................................................. 24
You can help with plan policies ....................................................................................................................... 25
Information from Member Services ................................................................................................................ 25
Options ............................................................................................................................................................... 26
1. If you want to leave HealthPlus Amerigroup .............................................................................................. 26
2. You could become ineligible for the HealthPlus Amerigroup Family Health Plus program ....................... 26
3. We can ask you to leave HealthPlus Amerigroup ..................................................................................... 27
4. You may want to change from Family Health Plus to Medicaid with a spenddown .................................. 27
5. If you become pregnant while enrolled in Family Health Plus .................................................................... 27
Action appeals .................................................................................................................................................. 28
External appeals ................................................................................................................................................. 31

FAIR HEARINGS .................................................................................................................................................... 33

COMPLAINT PROCESS .................................................................................................................................... 34
Complaint appeals ............................................................................................................................................. 35
How to make a complaint appeal ................................................................................................................... 35

MEMBER RIGHTS AND RESPONSIBILITIES ................................................................................................. 37
Quality Management program ......................................................................................................................... 39

ADVANCE DIRECTIVES .................................................................................................................................... 40

HIPAA NOTICE OF PRIVACY PRACTICES .................................................................................................... 41

IMPORTANT PHONE NUMBERS .................................................................................................................... 45
WELCOME TO THE HEALTHPLUS AMERIGROUP
FAMILY HEALTH PLUS 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 Family Health Plus (FHPlus) 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 people now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of FHPlus managed care health plans. In some counties, however, there may only be one plan that offers FHPlus. Under FHPlus, people must join a managed care health plan in order to be able to receive health care benefits.

HealthPlus Amerigroup has a contract with the State Department of Health to meet the health care needs of people in FHPlus. 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 Member Services to get a copy.

When you join our plan, one of our plan providers takes care of you. Most of the time that person will be your primary care provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange 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 and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases you can self-refer to certain doctors for some services. See page 12 for details.

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

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

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

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

When you have a question, check this handbook or call our Member Services department at 1-800-600-4441. You can also call the managed care staff at your Local Department of Social Services (LDSS). Be sure to tell them you are in the Family Health Plus program. If you live in New York City or Nassau 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 TTY line at 1-800-855-2880.

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

You can call to get help anytime you have a question. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report a pregnancy or the birth of a new baby, or ask about any change that might affect your benefits (for example, you get a job that offers health care coverage).

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

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

- TTY/TDD machine 1-800-855-2880
- Information in large print
- Case management
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

Your HealthPlus Amerigroup ID card

After you enroll, we’ll send you a welcome letter. Your HealthPlus Amerigroup ID card should arrive within 14 days after your enrollment date. Your card has your PCP’s name and phone number on it. It will also have your subscriber number (member number). If anything is wrong, call us right away.

Your ID card has HealthPlus Amerigroup phone numbers on the back. Carry your ID card at all times and show it each time you go for care.

If you need care before the card comes, your welcome letter is proof that you are a member. All the benefits that Family Health Plus covers can be accessed using your HealthPlus Amerigroup ID card.

Keep us informed

Call Member Services whenever these changes happen in your life:

- You change your name, address or telephone number.
- You have a change in circumstances that will affect your eligibility for Family Health Plus.
- You are pregnant.
- You give birth.
- You become covered under another health insurance plan.
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, you should do so right away.** If you do not choose a PCP within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.

With this handbook, you should have a **provider directory**. This is a list of all the doctors, clinics, hospitals, labs and others who work with HealthPlus Amerigroup. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:
- 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 provider’s professional qualifications or specialty, where he or she attended medical school and/or completed 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.

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

We also contract with Federally Qualified Health Centers (FQHCs). All FQHCs give primary and specialty care. Some clients want to get their care from FQHCs because the centers have a long history in the neighborhood. You may want to try them because they are easy to get to. You should know that you have a choice. You can choose one of our providers, or you can sign up with a PCP at one of the FQHCs that we work with. See your provider directory, look at the list on the next page or call Member Services for help at 1-800-600-4441.
<table>
<thead>
<tr>
<th>HealthPlus Amerigroup Federally Qualified Health Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amsterdam Avenue Family Health Center</strong></td>
</tr>
<tr>
<td>690 Amsterdam Ave.</td>
</tr>
<tr>
<td>New York, NY 10025</td>
</tr>
<tr>
<td>212-865-4104</td>
</tr>
<tr>
<td><strong>Lutheran Medical Center</strong></td>
</tr>
<tr>
<td>150 55th St.</td>
</tr>
<tr>
<td>Brooklyn, NY 11220</td>
</tr>
<tr>
<td>718-630-7000</td>
</tr>
<tr>
<td><strong>Beacon Christian Community Health Center Inc.</strong></td>
</tr>
<tr>
<td>2079 Forest Ave.</td>
</tr>
<tr>
<td>Staten Island, NY 10303</td>
</tr>
<tr>
<td>718-815-6560</td>
</tr>
<tr>
<td><strong>Morris Heights Health Center</strong></td>
</tr>
<tr>
<td>85 W. Burnside Ave.</td>
</tr>
<tr>
<td>Bronx, NY 10453</td>
</tr>
<tr>
<td>718-716-4400</td>
</tr>
<tr>
<td><strong>Bedford Stuyvesant Family Health Center</strong></td>
</tr>
<tr>
<td>1413 Fulton St.</td>
</tr>
<tr>
<td>Brooklyn, NY 11216</td>
</tr>
<tr>
<td>718-636-4500</td>
</tr>
<tr>
<td><strong>Mt. Hope Family Practice</strong></td>
</tr>
<tr>
<td>1731 Harrison Ave.</td>
</tr>
<tr>
<td>Bronx, NY 10453</td>
</tr>
<tr>
<td>718-583-9000</td>
</tr>
<tr>
<td><strong>Betances Health Center</strong></td>
</tr>
<tr>
<td>280 Henry St., # A</td>
</tr>
<tr>
<td>New York, NY 10002</td>
</tr>
<tr>
<td>212-227-8843</td>
</tr>
<tr>
<td><strong>New Cassel/Westbury Health Center</strong></td>
</tr>
<tr>
<td>682 Union Ave.</td>
</tr>
<tr>
<td>Westbury, NY 11590</td>
</tr>
<tr>
<td>516-571-9535</td>
</tr>
<tr>
<td><strong>Brooklyn Plaza Medical Center</strong></td>
</tr>
<tr>
<td>650 Fulton St.</td>
</tr>
<tr>
<td>Brooklyn, NY 11217</td>
</tr>
<tr>
<td>718-596-9800</td>
</tr>
<tr>
<td><strong>ODA Primary Care Health Center</strong></td>
</tr>
<tr>
<td>14 Heyward St.</td>
</tr>
<tr>
<td>Brooklyn, NY 11211</td>
</tr>
<tr>
<td>718-852-0803</td>
</tr>
<tr>
<td><strong>Brownsville Multi-services Family Health Center</strong></td>
</tr>
<tr>
<td>592 Rockaway Ave.</td>
</tr>
<tr>
<td>Brooklyn, NY 11212</td>
</tr>
<tr>
<td>718-345-5000</td>
</tr>
<tr>
<td><strong>Park Slope Family Health Center</strong></td>
</tr>
<tr>
<td>220 13th St.</td>
</tr>
<tr>
<td>New York, NY 11215</td>
</tr>
<tr>
<td>718-832-5980</td>
</tr>
<tr>
<td><strong>Brownsville Multi-services Family Health Center at Genesis</strong></td>
</tr>
<tr>
<td>592 Rockaway Ave.</td>
</tr>
<tr>
<td>Brooklyn, NY 11212</td>
</tr>
<tr>
<td>718-345-5000</td>
</tr>
<tr>
<td><strong>Parkchester Family Practice</strong></td>
</tr>
<tr>
<td>1597 Unionport Road</td>
</tr>
<tr>
<td>Bronx, NY 10462-5902</td>
</tr>
<tr>
<td>718-822-1818</td>
</tr>
<tr>
<td><strong>Charles B. Wang Community Health Center</strong></td>
</tr>
<tr>
<td>125 Walker St.</td>
</tr>
<tr>
<td>New York, NY 10013</td>
</tr>
<tr>
<td>212-379-6988</td>
</tr>
<tr>
<td><strong>Phillips Family Practice</strong></td>
</tr>
<tr>
<td>16 E. 16th St.</td>
</tr>
<tr>
<td>New York, NY 10003</td>
</tr>
<tr>
<td>212-206-5200</td>
</tr>
<tr>
<td><strong>CHN - Betty Shabazz Health Center</strong></td>
</tr>
<tr>
<td>999 Blake Ave.</td>
</tr>
<tr>
<td>Brooklyn, NY 11208</td>
</tr>
<tr>
<td>718-277-8303</td>
</tr>
<tr>
<td><strong>Ramon S Velez Health Center</strong></td>
</tr>
<tr>
<td>754 E. 151 St.</td>
</tr>
<tr>
<td>Bronx, NY 10455</td>
</tr>
<tr>
<td>718-402-2800</td>
</tr>
<tr>
<td>CHN - Bronx Center</td>
</tr>
<tr>
<td>--------------------</td>
</tr>
<tr>
<td>975 Westchester Ave.</td>
</tr>
<tr>
<td>Bronx, NY 10459</td>
</tr>
<tr>
<td>718-991-9250</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - CABS Center</th>
<th>Refuah Health Center - Twin Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>94-98 Manhattan Ave.</td>
<td>5 Twin Ave.</td>
</tr>
<tr>
<td>Brooklyn, NY 11206</td>
<td>Spring Valley, NY 10977</td>
</tr>
<tr>
<td>718-388-0390</td>
<td>845-354-9300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - Caribbean House Center</th>
<th>Refuah Health Center - South Fallsburg Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1167 Nostrand Ave.</td>
<td>South Fallsburg Family Medical</td>
</tr>
<tr>
<td>Brooklyn, NY 11225</td>
<td>36 Laurel Ave.</td>
</tr>
<tr>
<td>718-778-0198</td>
<td>South Fallsburg, NY 12779</td>
</tr>
<tr>
<td></td>
<td>845-354-9300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - Community League Center</th>
<th>Roosevelt/Freeport Family Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996 Amsterdam Ave.</td>
<td>380 Nassau Road</td>
</tr>
<tr>
<td>New York, NY 10032</td>
<td>Roosevelt, NY 11575</td>
</tr>
<tr>
<td>212-781-7979</td>
<td>516-571-8600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - Downtown Health Center</th>
<th>Ryan/Chelsea-Clinton Community Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>150 Essex St.</td>
<td>645 Tenth Ave.</td>
</tr>
<tr>
<td>New York, NY 10002</td>
<td>New York, NY 10036</td>
</tr>
<tr>
<td>212-477-1120</td>
<td>212-265-4500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - Helen B Atkinson Center</th>
<th>Ryan-Nena Community Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>81 W. 115th St.</td>
<td>279 E. Third St.</td>
</tr>
<tr>
<td>New York, NY 10026</td>
<td>New York, NY 10009</td>
</tr>
<tr>
<td>212-426-0088</td>
<td>212-477-8500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHN - Queens Center</th>
<th>Settlement Health &amp; Medical Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>97-04 Sutphin Blvd.</td>
<td>212 E. 106 St.</td>
</tr>
<tr>
<td>Jamaica, NY 11435</td>
<td>New York, NY 10029</td>
</tr>
<tr>
<td>718-657-7088</td>
<td>212-360-2600</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Health Center of Richmond</th>
<th>Sidney Hillman Family Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>235 Port Richmond Ave.</td>
<td>16 E. 16th St.</td>
</tr>
<tr>
<td>Staten Island, NY 10302</td>
<td>(Between Fifth Ave. &amp; W. Union Square)</td>
</tr>
<tr>
<td>718-876-1732</td>
<td>New York, NY 10003</td>
</tr>
<tr>
<td></td>
<td>212-924-7744</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Damian Family Care Center</th>
<th>Sunset Park Family Health Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>13750 Jamaica Ave.</td>
<td>150 55th St.</td>
</tr>
<tr>
<td>Jamaica, NY 11435</td>
<td>Brooklyn, NY 11220</td>
</tr>
<tr>
<td>718-298-5100</td>
<td>718-630-7095</td>
</tr>
<tr>
<td><strong>Dr. Martin Luther King, Jr. Health Center</strong></td>
<td><strong>Sunset Terrace Family Health Center</strong></td>
</tr>
<tr>
<td>1265 Franklin Ave.</td>
<td>514 49th St.</td>
</tr>
<tr>
<td>Bronx, NY 10456</td>
<td>Brooklyn, NY 11220</td>
</tr>
<tr>
<td>718-503-7700</td>
<td>718-431-2600</td>
</tr>
</tbody>
</table>

| **East 13th Street Family Practice** | **Urban Health Plan - Bella Vista Health Center** |
| 113 E. 13th St. | 1065 Southern Blvd. |
| New York, NY 10003 | Bronx, NY 10459 |
| 212-253-1830 | 718-589-2440 |
| | 212-517-1891 |

| **EHCHS Inc. Boriken Neighborhood Health Center** | **Urban Health Plan - El Nuevo San Juan Health Center** |
| 2253 Third Ave., Third Floor | 1065 Southern Blvd. |
| New York, NY 10035 | Bronx, NY 10459 |
| 212-289-6650 | 718-589-2440 |

| **Elmont Health Center** | **Urban Health Plan - Plaza Del Castilo Health Center** |
| 161 Hempstead Turnpike | 1515 Southern Blvd. |
| Elmont, NY 11003 | Bronx, NY 10460 |
| 516-571-8200 | 718-589-1600 |

| **Hempstead Health Center** | **Urban Horizons Family Practice** |
| 135 Main St. | 50 E. 168th St. |
| Hempstead, NY 11550-2414 | Bronx, NY 10452 |
| 516-572-1300 | 718-293-3961 |

| **Institute for Family Health - Sidney Hillman Family Practice** | **Walton Family Health Center** |
| 16 E. 16th St. | 1894 Walton Ave. |
| New York, NY 10003 | Bronx, NY 10453 |
| 212-633-0800, ext. 1337 | 718-583-3060 |
| 212-206-5200 (medical) | |

| **Joseph P. Addabbo Family Health Center** | **William F. Ryan Community Health Center** |
| 67-10 Rockaway Beach Blvd. | 110 W. 97th St. |
| Averne, NY 11692 | New York, NY 10025 |
| 718-945-7150 | 212-316-7906 |
In almost all cases, your doctors will be HealthPlus Amerigroup providers. There are two instances when you can still see another doctor that you had before you joined HealthPlus Amerigroup. In both cases, however, your doctor must agree to work with HealthPlus Amerigroup:

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

If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to choose a specialist to act as your PCP. Please call Member Services, and they will help you make this change.

If you need to, you can change your PCP in the first 30 days after your first appointment with your PCP. After that, you can change once every six months without cause or more often if you have a good reason. You can also change your OB-GYN or a specialist to whom your PCP has referred you.

**If your provider leaves HealthPlus Amerigroup, we will tell you within 15 days from when we know about this.** If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with HealthPlus Amerigroup during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-600-4441.

**How to get regular care**

Regular care means exams, regular checkups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your primary care provider (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 for one of the following reasons:

- 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 coverage and level of care and service; care that is consistent with health care practices accepted by professionally recognized health care organizations or governmental agencies; and consistent with the diagnosis of the condition. HealthPlus Amerigroup does not offer financial incentive or disincentives to the medical team who make these decisions.

HealthPlus Amerigroup medical director and network doctors review new medical advances. They do this to decide if these advances and new treatment 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. As soon as you choose a PCP, call to make a first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. If you can, prepare for your first appointment. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. 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.

- Your first appointment 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 second, one week during third)
- First family planning visit: within two weeks
- Follow-up after a behavioral health or inpatient visit: five days
- Nonurgent behavioral health visit: two weeks
How to get specialty care and a referral or a script

If you need care that your PCP cannot give, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, he or she will provide you with a referral or a script. You are not responsible for any costs except copays as described later in this handbook. Copays may apply for certain medical care and services. Most of these specialists are plan providers. If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. Talk with your PCP to find out how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask our plan to approve before you can get them. Your PCP will be able to tell you what they are. When your PCP refers you to a specialist, be sure to take your referral form or script with you to the specialist.

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

Refer to service authorization request in the Action appeals section for details. If your PCP or HealthPlus Amerigroup refers you to a provider outside of our network, you are not responsible for any costs except the usual copays as described later in this handbook.

Any decision to deny coverage of a service authorization request or to approve it for an amount that is less than requested is called an action. If you are not satisfied with our decision about your care, there are steps you can take. Refer to service authorization appeals in the Action appeals section for details or call HealthPlus Amerigroup Member Services at 1-800-600-4441 (TTY 1-800-855-2880).

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

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
• Your specialist to act as your PCP
• A referral to a specialty care center that deals with the treatment of your problem
• Hospice services if you are terminally ill

If you are having trouble getting a referral you think you need, contact Member Services at 1-800-600-4441 (TTY 1-800-855-2880).

You can also call Member Services for help in getting access to a specialty care center.
Get these services without a referral

Women’s services
You do not need a referral from your 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
- A medically necessary abortion

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

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

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

If you want HIV testing and counseling but not as part of a family planning service, your PCP can 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
You do not need a referral from your PCP for an eye exam or to get new glasses. You just choose one of our participating providers. But remember that you are limited to eye exams and new glasses once every two years. However, enrollees diagnosed with diabetes may to any participating provider for a dilated eye (retinal) examination once in any 12-month period. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

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

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

Examples of emergencies are:
- A heart attack or severe chest pain
- Bleeding that won’t stop or a bad burn
- Broken bones
- Trouble breathing/convulsions/loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have 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 primary care provider’s (PCP’s) approval before getting emergency care, and you are not required to use our hospitals or doctors.

If you are not sure, call your PCP or HealthPlus Amerigroup. Tell the person you speak with what is happening. Your PCP or HealthPlus Amerigroup Member Services representative will do one of the following:
- Tell you what to do at home
- Tell you to come to the PCP’s office
- Tell you to go to the nearest emergency room
If you are out of the area when you have an emergency, go to the nearest emergency room.

<table>
<thead>
<tr>
<th>Remember:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You do not need prior approval for emergency services.</td>
</tr>
<tr>
<td>• Use the emergency room only if you have an emergency.</td>
</tr>
<tr>
<td>• The emergency room should NOT be used for problems like the flu, sore throats or ear infections.</td>
</tr>
<tr>
<td>• If you have questions, call your PCP or HealthPlus Amerigroup at 1-800-600-4441.</td>
</tr>
</tbody>
</table>

**Nurse HelpLine**

If you are unsure whether to go to an emergency room, or if you just need help with getting medical advice, you can call the HealthPlus Amerigroup Nurse HelpLine 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 an episode of persistent vomiting or diarrhea, 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. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-600-4441. 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 you need, here are some other ways to keep you in good health:

- Health education classes
- Grief/loss support
- Stress management
- Prenatal care and nutrition
- Breastfeeding and baby care
- Stop-smoking classes
- Asthma counseling and self-management training
- Diabetes counseling and self-management training
- Weight control
- Cholesterol control

Call Member Services at 1-800-600-4441 to find out more and get a list of upcoming classes.
Case management services
HealthPlus 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. The team helps educate you about your condition and helps 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 question or would like to know more about our disease management programs, 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.
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 available under Family Health Plus (FHPlus). 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

FHPlus covers a comprehensive set of health care services or benefits. HealthPlus Amerigroup will provide or arrange for all of the covered services. You can get a few services, however, without going through your primary care provider (PCP); these include emergency care, family planning, HIV testing and counseling, and specific self-referral services as mentioned in Part 1.

Copayments

FHPlus members are required to make copayments (copays) when receiving certain medical care and services. Some people are exempt and do not have to make these payments. See the following list of services that require copays and information about who is exempt. If you have questions, you may call Member Services at 1-800-600-4441 or the Department of Health’s Family Health Plus Information Line at 1-855-693-6765.

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brand-name prescription drugs</td>
<td>$6 for each prescription and refill</td>
</tr>
<tr>
<td>Generic prescription drugs</td>
<td>$3 for each prescription and refill</td>
</tr>
<tr>
<td>Clinic visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Physician visit</td>
<td>$5 per visit</td>
</tr>
<tr>
<td>Dental service visit</td>
<td>$5 per visit up to a total of $25 per year</td>
</tr>
<tr>
<td>Lab tests</td>
<td>$0.50 per test</td>
</tr>
<tr>
<td>Radiology services (like diagnostic X-rays, ultrasound, nuclear medicine and oncology services)</td>
<td>$1 per radiology service</td>
</tr>
<tr>
<td>Inpatient hospital stay</td>
<td>$25 per stay</td>
</tr>
<tr>
<td>Nonurgent emergency room visit</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Over-the-counter medications (e.g., for smoking cessation and diabetes)</td>
<td>$0.50 per medication</td>
</tr>
<tr>
<td>Medical supplies (e.g., for diabetes and enteral formulae)</td>
<td>$1 per supply</td>
</tr>
</tbody>
</table>

To get certain medications we may require that your doctor get prior authorizations from us before writing your prescription. Your doctor can work with HealthPlus Amerigroup to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.
You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan, or you can fill your prescriptions by using a mail order pharmacy. For more information on your options, please contact Member Services at 1-800-600-4441 (TTY 1-800-855-2880).

Copays do not apply to the following services:
- Emergency services
- Family planning services and supplies
- Mental health clinics
- Chemical dependence clinics
- Mental illness drugs (psychotropic)
- Tuberculosis drugs
- Prescription drugs for a resident of an adult care facility

You do not have to pay the copays if you are:
- Under age 21
- Pregnant
- A resident of community based residential facility licensed by the Office of Mental Health or the Office For People With Developmental Disabilities
- Not able to pay the copay at any time, and you tell the provider that you are unable to pay

Family Health Plus members who cannot afford the copay may not be denied a service based on their inability to pay. Your provider cannot refuse to give you care or services because you are unable to pay. (However, you will still owe the unpaid copay amounts to the provider, and the provider may ask you for payment later or send you a bill.)

Services covered by our plan
You must get these services from the providers who are in our plan. All services must be medically necessary and provided or referred by your PCP.

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

Preventive care
- Regular checkups
- Tests and procedures ordered by your PCP or specialist
- Smoking cessation counseling. (Enrollees are eligible for six sessions in a calendar year.)
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees age 19 and 20 years
Maternity care
Women in FHPlus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size has changed. If you become pregnant while you are enrolled in FHPlus, you have a choice to make. You may want to change coverage from FHPlus to Medicaid. Medicaid covers more services than FHPlus, which you may or may not need, depending on your medical needs. However, you may need to see a different doctor if you change from FHPlus to Medicaid. You should discuss this choice with your doctor and the local Department of Social Services office or HRA so that you can make the decision that best meets your needs.

Your baby will be eligible for Medicaid. Babies can’t be covered under FHPlus – it is a program for adults from 19 through 64 years of age. In order to be sure your baby will have access to all the services covered by Medicaid, you need to let your local Department of Social Services or HRA office know when you are pregnant, and your doctor should notify HealthPlus Amerigroup. They can get started arranging for coverage for your baby before it is born, regardless of the choice you have made for yourself. You should select your baby’s doctor as soon as possible.

If you stay in FHPlus, we will cover:
- Pregnancy care
- Doctors/midwife and hospital services
- Postpartum care

Home health care
HealthPlus Amerigroup can arrange for some home health care visits (up to 40 per year), but this is generally only done to avoid your having to stay in a hospital. Your doctor must agree that your medical needs can be met at home with this help. Here are some times when this would be covered:
- Two postpartum home health visits and additional visits as medically necessary for high-risk women
- Other visits as needed and ordered by your PCP/specialist

Vision care
FHPlus covers emergency vision care and the following preventive and routine vision care provided once in any 24-month period:
- One eye exam
- Either one pair of prescription eyeglass lenses and frames or prescription contact lenses where medically necessary
- One pair of medically necessary occupational eyeglasses (Occupational eyeglasses are special glasses that help you perform your job duties.)
Dental care
HealthPlus Amerigroup believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, a company focused on providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleanings, X-rays, 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.

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

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

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

Hospital care
- Inpatient care
- Outpatient care
- Lab, X-ray or 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. These are called poststabilization services.
- For more about emergency services, see page 13.
Behavioral health services
HealthPlus Amerigroup will cover up to 60 outpatient visits and 30 inpatient visits a year for behavioral health services. Behavioral health services include chemical dependence services (including alcohol and substance abuse services) and mental health treatment services.

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

Specialty care
Includes the services of other practitioners, including:
- Occupational, physical and speech therapists – limited to 20 visits per therapy per calendar year
- Midwives
- Audiologists
- Cardiac rehabilitation
- Podiatrists if you are diabetic or under age 21

Other covered services
- Emergency ambulance
- Durable medical equipment (DME)
- Hospice services
- Hearing aids/supplies
- Prosthetics/orthotics
- Court ordered services, if covered by the plan
- Tuberculosis (TB) diagnosis and treatment – You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

If you have a medical emergency and need emergency transportation, call 911.

Nonemergency transportation for Nassau County members ages 19 or 20 who receive C/THP services
For Nassau County members who are 19 or 20 years old and are receiving C/THP services, LogistiCare manages HealthPlus Amerigroup nonemergency or routine trips to medically necessary medical appointments.

To schedule a routine ride to a medical appointment, you or your provider must call LogistiCare at least three days before your medical appointment. LogistiCare is available Monday through Friday from 8 a.m. to 5 p.m. Eastern time.

They can also help you schedule a return ride after your appointment. Just call the Reservation Line number. If your scheduled ride is more than 15 minutes late, to arrange a replacement ride, call the Ride Assist number.
- Reservation line: 1-877-564-5922
- Ride Assist: 1-866-481-9489
Pharmacy benefit

Family Health Plus members must use their plan ID card to get:

- Prescription drugs
- Insulin and diabetic supplies (e.g., insulin syringes, blood glucose test strips, lancets, and alcohol wipes)
- Smoking cessation agents, including over-the-counter (OTC) products
- Select OTC medications such as Prilosec OTC, Loratadine, Zyrtec and vitamins
- Hearing aid batteries
- Enteral formulae (You must use a pharmacy that accepts our plan.)
- Emergency contraception (six per calendar year)

Copays apply for most medications. Some members are not required to pay these copays. For a list of the copays, refer to the copay chart found on page 16.

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

Services not covered

These services are not available from HealthPlus Amerigroup. 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)
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of HealthPlus Amerigroup (unless HealthPlus Amerigroup or your PCP sends you to that provider)
- Those services not given an approval in advance by your PCP
- Personal care services
- Private duty nursing services
- Medical supplies (like bandages), nonprescription drugs (OTCs like aspirin)
- Nursing home stays that are permanent
- Physical exams for the purpose of employment
- Nonemergency transportation (unless you live in Nassau County and are 19 or 20 years old and receiving C/THP services)
Transportation services

Nonemergency transportation for New York City members ages 19 or 20 who receive C/THP services

Effective January 1, 2013, nonemergency transportation will be covered by regular Medicaid for New York City members 19 or 20 years old who are receiving C/THP services. LogistiCare manages nonemergency or routine trips to medically necessary medical appointments.

To get nonemergency transportation, you or your provider must 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 appointment date and time
- Address where you are going
- The doctor you are seeing

Nonemergency transportation includes personal vehicle, bus, taxi, ambulette and public transportation.
SERVICE AUTHORIZATION AND ACTIONS

Prior authorization and time frames

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

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

Asking for approval of a treatment or service is called a service authorization request. To get approval for these treatments or services you or your doctor needs to call the HealthPlus Amerigroup Medical Management department at 1-800-454-3730. If necessary, your doctor can call for an approval after hours and on weekends by calling this number.

If you have any questions, call the Member Services department at 1-800-600-4441. You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called concurrent review.

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 approving or 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 workdays 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 workdays. We will tell you by the third workday 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 the hospital 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 appeals section later in this handbook.

Other decisions about your care
Sometimes we will do a concurrent review on the care you are receiving to see if 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 FHPlus 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 HealthPlus Amerigroup. 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 on the appropriate care and services and the benefit coverage
• Understand that we do not reward providers or others if they approve or 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 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 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 which hospitals our health providers work with
• We will tell you in writing how our plan checks on the quality of care to our members
• If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by our plan.
• If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our plan
• If you ask, we will tell you:
  – Whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 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

Options

1. If you want to leave HealthPlus Amerigroup

You can try us for 90 days. You can ask to leave our plan for any reason at any time during those 90 days, if there is another FHPlus plan available where you live. If you do not leave during the first 90 days of your coverage, you must stay in the plan for nine more months, unless you have a good reason (good cause). At the end of your first year in our plan, if you want to, you can change to another plan if there is another FHPlus plan available where you live.

These are examples of good cause:

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

To disenroll or change plans:
Call New York Medicaid Choice at 1-800-505-5678 and tell them you want to transfer to another Family Health Plus plan. The New York Medicaid Choice counselors can help you disenroll or change health plans if there is another Family Health Plus plan available where you live.

You can transfer over the phone or ask for a Transfer Package. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

It will take between two and six weeks to process, depending on when your request is received. You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You could become ineligible for the HealthPlus Amerigroup Family Health Plus program

You may have to leave HealthPlus Amerigroup if you:

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

3. We can ask you to leave HealthPlus Amerigroup

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

4. You may want to change from Family Health Plus to Medicaid with a spenddown

FHPlus doesn’t cover all the services that Medicaid does (like medical supplies).

If you have medical needs that could be better met by Medicaid and you qualify, you may be eligible for Medicaid with a spenddown.

If your income is higher than that allowed for Medicaid, but you have medical bills that are greater than the amount your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:
- Are under age 21
- Are disabled or blind
- Have children under age 21
- Are over age 65 or
- Are pregnant (see below)

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

5. If you become pregnant while enrolled in Family Health Plus

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

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

You can file an action appeal.
If you are not satisfied with an action we took or what we decide about your service authorization request, you have 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 appeal?
In the case of a standard appeal, we will send you a letter to let you know we are working on your action appeal. This letter will be sent within 15 days of HealthPlus Amerigroup receiving your action appeal.

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

Nonclinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

You can also provide information to be used in making the decision. You can provide the information in person or in writing.

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

If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us:
- A written statement that the service you asked for is different from the service we have in our network
- Two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you and will not cause you more harm than the service we have in our network

You will be given the reasons for our decision and our clinical rationale if it applies. If you are still not satisfied, any further appeal rights you have will be explained to you or your personal representative. For further appeals, you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Time frames for action appeals
**Standard action appeals:** If we have all the information we need, we will tell you our decision in 30 days from your action appeal. A written notice of our decision will be sent within two business days from when we make the decision.
**Fast-track appeals:** If we have all the information we need, fast-track action appeal decisions will be made in two business days from your action appeal. We will tell you in three business days after giving us your appeal if we need more information. We will tell you our decision by phone and send a written notice later. If we need more information to make a standard or fast-track decision about your service coverage authorization action appeal, we will:

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

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the health plan to help decide your case.

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

Quality Management Department  
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 action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-800-206-8125.

If your original denial was because we said the service was not medically necessary or was experimental or investigational 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 case 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, or the out-of-network service was not different from a service that is available in our network, then 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 do one of the following:

- 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 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 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.
- Contact HealthPlus Amerigroup at 1-800-600-4441.

Your external appeal will be decided in 30 days. More time (up to five workdays) 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 one of the following applies:

- Your doctor says that a delay will cause serious harm to your health.
- 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 Family Health Plus benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Family Health Plus benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor’s decision stops or limits your Family Health Plus benefits. You must file a complaint with HealthPlus Amerigroup. If HealthPlus Amerigroup agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

If the services you are now getting are scheduled to end, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. However, if you choose to ask for services to be continued, and the fair hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

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
- By mail:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Manage 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
Corning Tower ESP Room 2019
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time.

You may also 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 business day. If we need more information to make a decision, we will tell you.

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

Quality Management Department
HealthPlus, an Amerigroup Company
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 a complaint appeal. You can do this yourself or ask someone you trust to file the complaint appeal for you. The appeal must be made in writing. If you make a complaint appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?
After we get your complaint appeal we will send you a letter within 15 business days. The letter will tell you:

- Who is working on your complaint appeal
- How to contact this person
- If we need more information
Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need you will know our decision in 30 business days. If a delay would risk your health you will get our decision in two business days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-800-206-8125.
MEMBER RIGHTS AND RESPONSIBILITIES

Your rights
As a member of HealthPlus Amerigroup, you have a right to:

• Be cared for with respect without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation. If you have questions or concerns about this right, call 1-800-600-4441 and ask for extension 34925 or visit healthplus.amerigroup.com.
• 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, expect that you will be able to participate in and make decisions about your own and your child’s health care if you are married.
• Continue as a member of HealthPlus Amerigroup 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. Tell us if you have problems with any health care staff – call Member Services.
• 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 treatment your provider suggests may have serious consequences for your 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 paper carefully.

This tells you who can see your protected health information (PHI) with and 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 protected health information (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

• Saved 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. MEMCOMM-0246-13 REV 9/10/13
• **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 not in this notice. Other things could be selling it or using it to sell things to you. 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.
- 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 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 healthplus.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 (ER) ..................................................
(Write number above)

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

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

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 or call 1-855-355-5777.