

# METROPLUSHEALTH MEMBER HANDBOOK



# **METROPLUSHEALTH CHILD HEALTH PLUS MEMBER HANDBOOK**

Revised April 2023



# **MetroPlus Health Plan**

## **Quick Reference Guide**

MetroPlusHealth Member Services	<b>1-800-303-9626</b>
MetroPlusHealth 24-Hour Hotline	<b>1-800-442-2560</b>
MetroPlusHealth TDD Telephone	<b>1-800-881-2812</b>
MetroPlusHealth Website	<b><u><a href="http://www.metroplus.org">www.metroplus.org</a></u></b>

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### **WHAT IS AN EMERGENCY?**

Examples include:

Broken bones, trouble breathing, seizures (fits), severe bleeding, medicine overdose, loss of consciousness, paralysis, severe chest pain, heart attack, stroke.

If pregnant: vaginal bleeding, severe abdominal pain or cramps, water breaking or leaking.

**WHAT TO DO:** Call 911 or go immediately to the nearest Emergency Room.

### **WHAT IS AN URGENT HEALTH CARE PROBLEM?**

**Examples include:**

A serious health problem that does not require an Emergency Room: flu, earache, sore throat.

**WHAT TO DO?** Call your PCPs office Monday to Friday from 8:30a.m. to 5:30p.m. All other times call the 24-Hour Health Care Hotline number above.

**(MetroPlus Health Plan is operated by the New York City Health and Hospitals Corporation)**





**METROPLUSHEALTH  
MEMBER ANNUAL  
HEALTH ASSESSMENT  
FORM |  
TELL US HOW  
YOU'RE DOING.**



**PLEASE COMPLETE IN FULL AND MAIL BACK TO US AT:  
MetroPlus Health Plan • 50 Water Street, 7th Floor • New York, NY 10004**

**First, Last Name:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Height:** \_\_\_\_ft. \_\_\_\_ in. **Weight:** \_\_\_\_lbs.

**Preferred Language:**  English  Spanish  Chinese  Creole  Urdu  Bengali  Other: \_\_\_\_\_

**Race:**  White American Indian  Alaskan Native  Asian  Black / African American

Native Hawaiian / Pacific Islander  Two or More Races  Other: \_\_\_\_\_  Decline to answer

**Ethnicity:**  Hispanic or Latino  Non Hispanic or Latino  Decline to answer

**In general, would you say that your health is:**  Excellent  Good  Fair  Poor

**Would you like us to call you to help you with any urgent health problem?**  Yes  No

**Do you have a doctor you see regularly?**  Yes  No

**If Yes, has your doctor advised you to start, increase, or maintain some level of exercise or physical activity? (for example, start taking the stairs, increase walking from 10 to 20 minutes every day or to maintain your current exercise program)?**  Yes  No

**Do you have any of the following?**  Diabetes  Heart problems  High blood pressure  Cancer

Breathing problems (asthma or COPD)  Memory problems  Hearing problems  Vision problems

Mental / emotional problems  Urinary Incontinence  HIV  Drug or alcohol problems

Other medical problems: \_\_\_\_\_

**How many different medicines do you take a day?**  None  1-3  4-7  8 or more

**Do you need help with your basic activities (such as getting dressed, taking a bath, eating, getting in / out of a chair)?**  I'm able to do this without help  I need help, and get the help I need

I need help, and do not get the help I need

**Do you need help with housekeeping, taking medication, shopping, money management, preparing meals, or transportation?**  I'm able to do this without help

I need help, and get the help I need  I need help, and do not get the help I need

**In the past 6 months, have you ever had to go without healthcare because you didn't have a way to get there?**  Yes  No

**Did you fall in the past 6 months?**  Yes  No

**Does anyone in your life hurt, threaten, frighten you, or make you feel unsafe?**

Yes  No  Prefer not to answer

**Do you use any of the following:**

Cane  Walker  Wheelchair  Hospital bed  Oxygen  Protective Briefs / Pads (Adult diapers)

Other \_\_\_\_\_

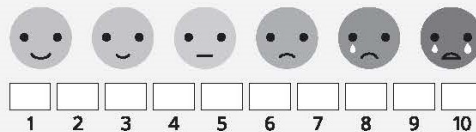
**Do you have repeated or ongoing pain?**

Yes  No **If yes, start date:** \_\_\_\_\_

**If yes, where is the pain?** \_\_\_\_\_

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

**If yes, mark off your level of pain here:**



**What is your living situation?**

I have a steady place to live  I have a place to live today, but I am worried about losing it in the future

I do not have a steady place to live (temporarily staying with others, in a hotel, shelter, living outside on street, on a beach, in a car, abandoned building, bus or train station, park, other)

**Are you worried that the place you are living now is making you sick?** (i.e. mold, bugs / rodents, water leaks, not enough heat, other)  Yes  No  Other: \_\_\_\_\_

**Do you currently receive public assistance (Food Stamps, Meals on Wheels, HEAP, EPIC, public or cash assistance, etc.)?**  Yes  No  I do not know

**In the past year, did you worry that your food could run out before you got money to buy more?**

Yes  No  Prefer not to answer

**In the past year, has the electric, gas, oil, or water company threatened to shut off services to your home?**

Yes  No  I do not know

**Do you smoke cigarettes, vape (e-cigarettes), or use tobacco?**  Current  Former  Never

**Did you get the Influenza Vaccine (Flu Shot) this year?**  Yes  No  I do not know

**Please list your medications** (list additional medications of an extra sheet, if applicable):

**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

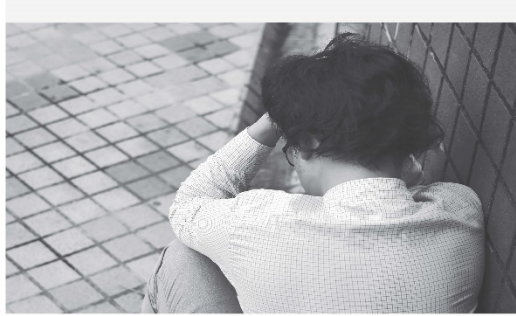
**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

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**Medication Name:** \_\_\_\_\_ **Dose:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Medication List** (continued - list additional medications of an extra sheet, if applicable):

Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
Medication Name: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_



**Over the past 2 weeks, how often have you had little interest or pleasure in doing things?**

- Not at all  Several Days  
 More than half of those days  Almost every day

**Over the past 2 weeks, how often have you felt down, depressed, or hopeless?**

- Not at all  Several Days  
 More than half of those days  Almost every day

**ONLY WOMEN 50 YEARS OLD AND UNDER: Are you pregnant?**  Yes  No  I do not know

**ONLY WOMEN 50-74 YEARS OLD: Did you have a mammogram (to check for breast cancer) this year or last?**  Yes  No  I do not know

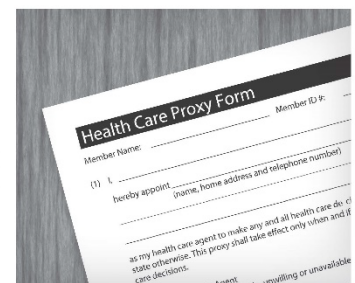
**ONLY THOSE 50-75 YEARS OLD: Did you have the following tests to check for colon cancer?**

- Colonoscopy (in the past 10 yrs.)  Sigmoidoscopy (in the past 5 yrs.)  
 Stool Test for blood (within the last yr.)

**Do you have any of the following?**

- Advance Directive / Living Will (a document that says what medical treatment you would like if you are unable to speak for yourself)**  
 **Health Care Proxy (a person who can make health care decisions for you, if you are not able to)**  
 **No, but advanced care planning was discussed with me**  
 **No, and advanced care planning was not discussed with me**  
 **No, but I am interested to learn more:**  Yes\*  No

\* We will send you an Advance Directive and Health Care Proxy Form



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MetroPlus Health Plan • 50 Water Street, 7th Floor • New York, NY 10004**





Dear Child Health Plus (CHPlus) Member:

Please read the IMPORTANT information below about your dental coverage. This information replaces the information on page 15 of this handbook.

## Services Covered by MetroPlus Health Plan

### Dental Benefit

MetroPlus Health Plan believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with DentaQuest, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

### How to Access Dental Services:

MetroPlusHealth uses DentaQuest to provide dental services. DentaQuest has participating dental providers who specialize in general dentistry, pediatric dentistry, oral surgery, gum disease, and orthodontia. Call DentaQuest at 1-844-284-8819 to choose a primary care dentist. You will find a listing of participating dental providers in your Provider Directory, online at **metroplus.org**, or you can obtain a listing upon request by calling MetroPlusHealth Member Services at 1-800-303-9626. You can always change your primary care dentist. Call your current primary care dentist to ask if he/she participates with DentaQuest.

- If you need to find a dental provider or change your primary care dentist, please call DentaQuest at 1-844-284-8819 or MetroPlus Health Plan at 1-800-303-9626. Customer Services Representatives are there to help you. Many speak your language.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your primary care dentist, you should show your plan ID card.
- You can also go to a dental clinic that is run by an academic dental center without a referral. Call the New York State Hotline at 800-541-2831 and they will send you a list of "dentists in your neighborhood."



New York State's Health Plan for Kids



# **Child Health Plus**

## **Subscriber Contract**

Thank you for choosing MetroPlus Health Plan. This booklet contains your Child Health Plus Contract with MetroPlus Health Plan and other information about the Plan that will help you make the most of your Child Health Plus benefits. Please take the time to read it carefully.

### **YOUR METROPLUS HEALTH PLAN CHILD HEALTH PLUS SUBSCRIBER CONTRACT**

PART I of this booklet is your Child Health Plus Contract with MetroPlus Health Plan. It entitles you to the benefits set forth in the Contract. Coverage begins on the effective date stated on your identification card. This Contract will continue unless it is terminated for any of the reasons described in the Contract.

#### **Notice of 10-Day Right to Examine Contract**

You have the right to return this Contract. Examine it carefully. You may return it and ask us to cancel it. Your request must be made in writing within ten (10) days of the date you receive this Contract. We will refund any premium you paid. If you return this contract, we will not provide you with any benefits.

#### **IMPORTANT NOTICE:**

All services covered under this Contract must be provided, arranged or authorized by your Primary Care Provider. You must contact your Primary Care Provider in advance in order to receive benefits, except for emergency care described in Section Seven, certain obstetric and gynecological care described in Section Four, and vision care and dental care described in Section Six of this Contract.

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## Model Child Health Plus Subscriber Contract Language

January 1, 2023

This rider amends your subscriber contract by adding the following benefits:

**Assertive Community Treatment Services.** We will pay for Assertive Community Treatment Services (ACT), Young Adult ACT and Youth ACT. Services must be referred by a physician or other licensed provider of the healing arts, within their scope of practice under State law, for maximum reduction of physical or intellectual disability and restoration of a beneficiary to his best possible functional level.

**Medical Supplies.** We will pay for Medical Supplies which have been ordered by a provider in the treatment of a specific medical condition and which are usually consumable, nonreusable, disposable and for a specific purpose and generally have no salvageable value.

**Orthodontic Services for a Severe Physically Handicapping Malocclusion.** We will pay for orthodontic services for a severe physically handicapping malocclusion. Prior approval for orthodontia coverage is required. Services include orthodontic care for severe physically handicapping malocclusions as a once in a lifetime benefit that will be reimbursed for an eligible member for a maximum of three years of active orthodontic care, plus one year of retention care. Retreatment for relapsed cases is not a covered service. Treatment must be approved and active therapy begun (appliances placed and activated) prior to the member's 19th birthday.

**Air Ambulance Services.** We will pay for air ambulance services for catastrophic, life-threatening illnesses or conditions when; rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; ground transport is not appropriate for the patient; or life-support equipment and advanced medical care is necessary during transport.

**Transportation Between Facilities.** We will pay for air and ground transportation between facilities when such services are considered emergency transports. This includes transport from an Emergency Room to a Psychiatric Center; transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center; transportation from an Emergency Room to an Emergency Room and transportation from an Emergency Room to Another Facility. Prior authorization is not required.

**Children and Family Treatment and Support Services.** We will pay for Children and Family Treatment and Support Services (CFTSS). Services may be delivered in the community where the child/youth lives, attends school and/or engages in services. Services include: Services provided by Other Licensed Professionals (OLP), Crisis Intervention, Community Psychiatric Supports and Treatment (CPST), Psychosocial Rehabilitation Services, Family Peer Support Services, Youth Peer Support.

**Core Limited Health-Related Services.** We will pay for Core Limited Health-Related Services at a Voluntary Foster Care Agency (VFCA) /29-I Health Facility. Health and behavioral health care services must meet reasonable and acceptable standards of health practice as determined by the State in consultation with recognized health organizations. Services include the following five Core Limited Health-Related Services: Skill building services; Nursing Services; Treatment Planning and Discharge Planning; Clinical Consultation/Supervision Services and VFCA Child Health Plus Liaison/Administrator.

## **CHPlus Subscriber Contract Benefit Update**

### **Hospice Services:**

Hospice provides palliative and supportive care that focuses on pain and symptom management related to the terminal illness and related conditions. We will pay for medically necessary curative and supportive services that are included in the benefit package for children up to the age of 21 who are receiving hospice care and who have been certified by a doctor to be terminally ill with a life expectancy of six months or less; regardless of the setting in which these services are rendered.

MetroPlusHealth will cover palliative and supportive care provided to a child that meets the special needs arising out of physical, psychological, spiritual, social and economic stress, which are experienced during the final stages of illness and during dying and bereavement. Additionally, family members are eligible for up to five visits for bereavement counseling.

Section 2302 of the Affordable Care Act entitled, "Concurrent Care for Children," amends sections 1905(0)(1) and 2110(a)(23) of the Social Security Act by removing the prohibition that children eligible for the Children's Health Insurance Program (CHIP) forgo receiving curative treatment for a terminal illness upon the election of the hospice benefit. The new provision requires that states make hospice services available to children without forgoing any other service to which the child is entitled under CHIP for treatment of the terminal condition.

Hospice service programs must be certified under Article 40 of the New York State Public Health Law. All services must be provided by qualified employees and volunteers of the hospice program or by qualified staff through contractual arrangements to the extent permitted by federal and state requirements.

**Autism Spectrum Disorder.** We will provide coverage for the following services when such services are prescribed or ordered by a participating network licensed physician or a licensed psychologist and are determined by us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this [section], "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

**1. Screening and Diagnosis.** We will provide coverage for assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

**2. Assistive Communication Devices.** We will cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, we will provide coverage for the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist for members who are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide the member with improved communication. Examples of assistive communication devices include communication boards and speech generating devices. Our coverage is limited to dedicated devices; we will only cover devices that generally are not useful to a person in the absence of a communication impairment. We will determine whether the device should be purchased or rented. We will not cover items, such as, but not limited to, laptops, desktops, or tablet computers. We will, however, cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. Repair and replacement of such devices are covered when made necessary by normal wear and tear. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not covered; however, we will cover one replacement or repair per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to the member's current functional level. No coverage is provided for the additional cost of equipment or accessories that are not Medically Necessary. We will not provide coverage for delivery or service charges or for routine maintenance. Prior approval of assistive communication devices is required. Refer to the prior approval procedures in your Contract.

**3. Behavioral health treatment.** We will provide coverage for counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such coverage when provided by a licensed provider. We will provide coverage for applied behavior analysis when provided by a behavior analyst certified pursuant to the Behavior Analyst Certification Board or an individual who is supervised by such a certified behavior analyst and who is subject to standards in regulations promulgated by the New York Department of Financial Services in consultation with the New York Departments of Health and Education. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications,

using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms. Our coverage of applied behavior analysis services is limited to 680 hours per Member per Calendar Year.

**4. Psychiatric and Psychological care.** We will provide coverage for direct or consultative services provided by a psychiatrist, psychologist, or licensed clinical social worker licensed in the state in which they are practicing.

**5. Therapeutic care.** We will provide coverage for therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such providers are otherwise covered under this Contract. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any aggregate visit maximums applicable to services of such therapists or social workers under this Contract.

**6. Pharmacy care.** We will provide coverage for prescription drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under title eight of the Education Law. Our coverage of such prescription drugs is subject to all the terms, provisions, and limitations that apply to prescription drug benefits under your Contract. We will not provide coverage for any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law.



## **CHPlus Ostomy Equipment and Supplies Rider**

**Effective May 1, 2015**

We will pay for ostomy equipment and supplies prescribed by a licensed health care provider legally authorized to prescribe under title eight of the Education Law.

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**PART I**  
**YOUR SUBSCRIBER CONTRACT**

**SECTION ONE - INTRODUCTION**

1. **Child Health Plus Program.** This Contract is being issued pursuant to a special New York State Department of Health (DOH) program designed to provide subsidized health insurance coverage for uninsured children in New York State. MetroPlus Health Plan will enroll you in the Child Health Plus program if you meet the eligibility requirements established by New York State and you will be entitled to the health care services described in this Contract. You and/or the responsible adult, as listed on the application, must report to us any change in status, such as residency, income, or other health insurance, that may make you ineligible for participation in Child Health Plus within 60 days of that change.
  
2. **Health Care through an HMO.** This Contract provides coverage through MetroPlus Health Plan, which is a health maintenance organization (HMO). In an HMO, all care must be Medically Necessary and provided, arranged or authorized in advance by your Primary Care Provider (PCP). Except for Emergency Services, certain obstetric and gynecological services, vision care and dental care, there is no coverage for care you receive without the approval of your PCP. In addition, coverage is only provided for care rendered by a Participating Provider, except in an emergency or when your PCP refers you to a Non-Participating Provider with the approval of MetroPlusHealth.  
  
**Selecting a PCP.** It is your responsibility to select a PCP from the MetroPlus Health Plan list of PCPs when you enroll for this coverage. The list includes a phone number to call to find out if a provider is accepting new patients. You may change your PCP by calling MetroPlusHealth Member Services toll free at **1-800-303-9626**.. The PCP you have chosen is referred to as "your PCP" throughout this Contract.
  
3. **Words We Use.** Throughout this Contract, MetroPlus Health Plan will be referred to as "we", "us" or "our." The words "you", "your" or "yours" refer to you, the child to whom this Contract is issued and who is named on the identification card.
  
4. **Definitions.** The following definitions apply to this Contract:

- A. **Contract** means this document. It forms the legal agreement between you and us. Keep this Contract with your important papers so it is available for your reference.
- B. **Emergency Condition** means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (A) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (B) serious impairment of such person's bodily functions; or (C) serious dysfunction of any bodily organ or part of such person; or (D) serious disfigurement of such person.
- C. **Emergency Services** means those physician and outpatient hospital services necessary for treatment of an Emergency Condition.
- D. **Hospital** means a short-term, acute, general hospital, which:
- is primarily engaged in providing, by or under the continuous supervision of physicians, to inpatients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
  - has organized departments of medicine and major surgery;
  - has a requirement that every patient must be under the care of a physician or dental provider;
  - provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
  - if located in New York State, has in effect a hospitalization review plan applicable to all patients which meets at least the standards set forth in Section 1861 (k) of United States Public Law 89-97 (42 USCA 1395x[k]);
  - is duly licensed by the agency responsible for licensing such hospitals; and
  - is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, education or rehabilitary care.

- E. **Medically Necessary** applies to those services and supplies which are necessary to prevent, diagnose, correct or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap. These services must be (1) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice as recognized and accepted by the medical community; (3) not solely for the convenience of the member, his or her provider, contractor, or other health care provider; and (4) in the case of inpatient hospital services, Medically Necessary shall also mean that safe and adequate care could not be provided as appropriately on an outpatient basis or in a less intensive treatment setting.
- F. **Participating Hospital** means a Hospital authorized under an agreement with us to provide covered services to our members.
- G. **Participating Pharmacy** means a pharmacy authorized under an agreement with us to provide covered services to our members.
- H. **Participating Physician** means a physician authorized under an agreement with us to provide covered services to our members.
- I. **Participating Provider** means any Participating Physician, dental provider or other licensed health care practitioner, Hospital, home health care agency, laboratory, pharmacy, or other entity, authorized under an agreement with us to provide covered services to our members.
- J. **Non-Participating Provider** means a provider who is not authorized under an agreement with us to provide covered services to our members. We will not pay for health services from a Non-Participating Provider except in an emergency or when your PCP sends you to that Non-Participating Provider with our approval.
- K. **Premium** means the money paid for health insurance coverage. New York State will pay for all or part of your premium; you may have to contribute part of the payment, depending on your income. (See Section 9 for more information.)

- L. **Primary Care Provider ("PCP")** means the Participating Provider (physician or nurse practitioner) you select when you enroll, or change to thereafter according to our rules, and who provides or arranges for all your covered health care services.
- M. **Service Area** means the following counties: Manhattan, Bronx, Queens, and Brooklyn. You must reside in the Service Area to be covered under this Contract.

## SECTION TWO - WHO IS COVERED

1. **Who is Covered Under this Contract.** You are covered under this Contract if you meet all of the following requirements:
  - You are younger than age 19.
  - You do not have other health care coverage.
  - You are not eligible for Medicaid.
  - You are a permanent New York State resident and a resident of our Service Area.
2. **Recertification.** We will review your application for coverage to determine if you meet the Child Health Plus eligibility requirements. You must periodically resubmit an application to us so that we can determine whether you still meet the eligibility requirements. This process is called "**recertification**". If more than one child in your family is currently covered by us, then the recertification date for all the children in your family covered by us is the month assigned to the child who has the closest recertification date on or after **October 1, 2000**. You must recertify once each year unless another child in your family applies for coverage with us, then you must recertify all children when that child applies for coverage. Thereafter, all the children in your family covered by us will recertify each year on the same date.
3. **Change in Circumstances.** You must notify us of any changes to your income, residency or health care coverage that might make you ineligible for this contract. You must give us this notice within sixty (60) days of the change. If you fail to give us notice of a change in circumstances, you may be asked to pay back any premium that has been paid for you.

## SECTION THREE - HOSPITAL BENEFITS

1. **Care in a Hospital.** You are covered for Medically Necessary care as an inpatient in a Hospital if all the following conditions are met:
  - A. The Hospital must be a Participating Provider except if you are admitted to a non-participating Hospital for Emergency Services or your PCP arranged the admission to a non-participating Hospital with authorization in advance by MetroPlusHealth.
  - B. Your admission must be authorized in advance by MetroPlusHealth, except for Emergency Services.
  - C. You must be a registered bed patient for the proper treatment of an illness, injury or condition that cannot be treated on an outpatient basis.
  
2. **Covered Inpatient Services.** Covered inpatient services under this Contract include the following:
  - A. Daily bed and board, including special diet and nutritional therapy;
  - B. General, special and critical care nursing service, but not private duty nursing service;
  - C. Facilities, services, supplies and equipment related to surgical operations, recovery facilities, anesthesia, and facilities for intensive or special care;
  - D. Oxygen and other inhalation therapeutic services and supplies;
  - E. Drugs and medications that is not experimental;
  - F. Sera, biologicals, vaccines, intravenous preparations, dressings, casts, and materials for diagnostic studies;
  - G. Blood products, except when participation in a volunteer blood replacement program is available;
  - H. Facilities, services, supplies and equipment related to diagnostic studies and the monitoring of physiologic functions, including but not limited to laboratory, pathology, cardiographic, endoscopic, radiologic and electroencephalographic studies and examinations;



- I. Facilities, services and supplies related to physical medicine and occupational therapy and rehabilitation;
  - J. Facilities, services and supplies and equipment related to radiation and nuclear therapy;
  - K. Facilities, services, supplies and equipment related to emergency medical care;
  - L. Chemotherapy;
  - M. Radiation therapy; and
  - N. Any additional medical, surgical, or related services, supplies and equipment that are customarily furnished by the Hospital, except to the extent that they are excluded by this Contract.
3. **Maternity Care.** Other than for perinatal complications, we will pay for inpatient hospital care for at least 48 hours after childbirth for any delivery other than a Caesarean Section. We will pay for inpatient hospital care for at least 96 hours after a Caesarean Section. Maternity care coverage includes parent education, assistance and training in breast or bottle-feeding and performance of necessary maternal and newborn clinical assessments.

You have the option to be discharged earlier than 48 hours (96 hours for Cesarean Section). If you choose an early discharge, we will pay for one home care visit if you ask us to within 48 hours of delivery (96 hours for a delivery by Cesarean Section). The home care visit will be delivered within 24 hours of the later of your discharge from the Hospital or your request for home care. The home care visit will be in addition to home care visits covered under Section Six of this Contract.

4. **Inpatient Mental Health, Alcohol and Substance Abuse Services.** In the case of mental health services and alcohol and substance abuse services, we will pay for covered inpatient services provided in: Hospitals; facilities operated by OMH under Section 7.17 of the Mental Hygiene Law; and facilities issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law. Except in an emergency, the provider must be a Participating Provider unless we authorize admission to a Non-Participating Provider.

## 5. **Limitations and Exclusions**

- A. We will not provide any benefits for any day that you are out of the hospital, even for a portion of the day. We will not provide benefits for any day when inpatient care was not Medically Necessary.
- B. Benefits are paid in full for a semi-private room. If you are in a private room, the difference between the cost of a private room and a semi-private room must be paid by you unless the private room is Medically Necessary and ordered by your physician.
- C. We will not pay for non-medical items such as television rental or telephone charges.

## **SECTION FOUR - MEDICAL SERVICES**

### 1. **Your PCP Must Provide, Arrange or Authorize all Medical Services.**

Except for Emergency Services or for certain obstetric and gynecological services, you are covered for the medical services listed below only if your PCP provides, arranges or authorizes the services. You are entitled to medical services provided at one of the following locations:

- Your PCP's office.
- Another provider's office or a facility if your PCP determines that care from that provider or facility is appropriate for the treatment of your condition.
- The outpatient department of a Hospital.
- As an inpatient in a Hospital, you are entitled to medical, surgical and anesthesia services. MetroPlusHealth must authorize in advance all non-emergency Hospital admissions.

### 2. **Covered Medical Services.** We will pay for the following medical services:

- A. General medical and specialist care, including consultations.
- B. Preventive health services and physical examinations.** We will pay for preventive health services including:
  - Well child visits in accordance with the visitation schedule established by the American Academy of Pediatrics,
  - Nutrition education and counseling,

- Hearing testing,
- Medical social services,
- Eye screening,
- Routine immunizations in accordance with those recommended by the Advisory Committee on Immunization Practices,
- Tuberculin testing,
- Dental and developmental screening,
- Clinical laboratory and radiological testing, and
- Lead screening.

C. **Diagnosis and Treatment of Illness, Injury or Other Conditions.**

We will pay for the diagnosis and treatment of illness or injury including:

- Outpatient surgery performed in a provider's office or at an ambulatory surgery center, including anesthesia services,
- Dental care in connection with accidental injury to sound natural teeth within twelve months of the accident,
- Laboratory tests, X-rays and other diagnostic procedures,
- Renal dialysis,
- Radiation therapy,
- Chemotherapy,
- Injections and medications administered in a physician's office,
- Second surgical opinion from a board certified specialist, and
- Medically Necessary audiometric testing.

D. **Physical and Occupational Therapy.** We will pay for Short-Term physical and occupational therapy services. The therapy must be skilled therapy. Short-Term means not to exceed forty (40) visits within one calendar year.

E. **Radiation Therapy, Chemotherapy and Hemodialysis.** We will pay for radiation therapy and chemotherapy, including injection and medications provided at the time of therapy. We will pay for hemodialysis services in your home or at a facility, whichever we deem appropriate.

**F. Outpatient Visits for Treatment of Mental Health Conditions and for Treatment of Alcoholism and Substance Abuse.**

We will pay for outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. Medically necessary services are covered, without limitations on the number of visits. Visits include family therapy for alcohol, drug and/or mental health as long as such therapy is directly related to the enrolled child's alcohol, drug and/or mental health treatment.

**G. Obstetric and Gynecological Services** including prenatal, labor and delivery and post-partum services are covered with respect to pregnancy. You do not need your PCP's authorization for care related to pregnancy if you seek care from a qualified Participating Provider of obstetric and gynecologic services. You may also receive the following services from a qualified Participating Provider of obstetric and gynecologic services without your PCP's authorization:

- Up to two annual examinations for primary and preventive obstetric and gynecologic care; and
- Care required as a result of the annual examinations or as a result of an acute gynecological condition.

**H. Cervical Cancer Screening.** If you are a female who is eighteen years old, or younger and sexually active, we will pay for an annual cervical cancer screening, an annual pelvic examination, pap smear and evaluation of the pap smear. We will also pay for screening for sexually transmitted diseases.

**I. Speech Therapy.** We will pay for speech therapy services required for a condition amenable to significant clinical improvement within a two month period, beginning with the first day of therapy, when performed by an audiologist, language pathologist, a speech therapist and/or otolaryngologist.

## SECTION FIVE - EMERGENCY CARE

1. **Hospital Emergency Room Visits.** We will pay for Emergency Services provided in a Hospital emergency room. You may go directly to any emergency room to seek care. You do not have to call your PCP first. Emergency care is not subject to our prior approval.

MetroPlusHealth recommends that if you go to the emergency room, you or someone on your behalf notify the MetroPlusHealth Utilization Management Department by the next business day or as soon as it is reasonably possible. To notify us, call the Utilization Management toll-free telephone number: **1-800-303-9629.**

If, in our sole judgment, the emergency room services rendered were not in treatment of an Emergency Condition as defined in Section One, page 4, the visit to the emergency room will not be covered.

2. **Emergency Hospital Admissions.** If you are admitted to the Hospital you or someone on your behalf must notify the MetroPlusHealth Utilization Management Department by the next business day or as soon as it is reasonably possible. If you are admitted to a non-participating hospital, we may require that you be moved to a Participating Hospital as soon as your condition permits.
3. **Ambulance Services.** We will pay for pre-hospital emergency medical services, including prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a hospital, provided by an ambulance service issued a certificate to operate pursuant to section 3005 of the Public Health Law.

You do not need our prior approval to obtain ambulance services for an Emergency Condition as defined under the prudent layperson standard set forth in Section One, page 2. If pre-hospital emergency medical services, including evaluation and treatment and/or non-airborne transportation to a hospital, are necessary under the prudent layperson standard, they will be covered. Ambulance services rendered in the absence of an Emergency Condition will not be covered.

## **SECTION SIX - MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES**

- 1. Inpatient Mental Health and Substance Use Disorder Services** There are no limitations for inpatient mental health services, inpatient detoxification and inpatient rehabilitation as long as the treating facility operates under State regulations.

We will pay for inpatient mental health services and inpatient substance use disorder services when such services are provided in a facility that is:

- Operated by the Office of Mental Health under section 7.17 of the Mental Hygiene Law;
- Issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law; or
- A general hospital as defined in Article 28 of the Public Health Law.

**Outpatient Visits for Treatment of Mental Health Conditions and for Treatment of Substance Use Disorder** We will pay for the outpatient visits for the diagnosis and treatment of mental health conditions and substance use disorders. We will also pay for outpatient visits for your family members if such visits are related to your mental health or substance use disorder treatment.

## **SECTION EIGHT - OTHER COVERED SERVICES**

- 1. Diabetic Equipment and Supplies.** We will pay for the following equipment and supplies for the treatment of diabetes which are Medically Necessary and prescribed or recommended by your PCP or other Participating Provider legally authorized to prescribe under Title 8 of the New York State Education Law:

- Blood glucose monitors,
- Blood glucose monitors for legally blind,
- Data management systems,
- Test strips for monitors and visual reading,
- Urine test strips,
- Injection aids,
- Cartridges for the legally blind,
- Insulin,

- Syringes,
- Insulin pumps and appurtenances thereto,
- Insulin infusion devices,
- Oral agents, and
- Additional equipment and supplies designated by the Commissioner of Health as appropriate for the treatment of diabetes.

2. **Diabetes Self-Management Education.** We will pay for diabetes self-management education provided by your PCP or another Participating Provider. Education will be provided upon the diagnosis of diabetes, a significant change in your condition, the onset of a condition which makes changes in self-management necessary or where re-education is Medically Necessary as determined by us. We will also pay for home visits if Medically Necessary.

3. **Durable Medical Equipment.**

A. **Scope of Coverage.** We will pay for devices and equipment that are ordered by your PCP or other Participating Provider for the treatment of a specific medical condition and which:

- Can withstand repeated use for a protracted period of time;
- Are primarily and customarily used for medical purposes;
- Are generally not useful in the absence of illness or injury;
- and
- Are usually not fitted, designed or fashioned for a particular person's use, though equipment intended for use by one person may be custom-made or customized.

Durable medical equipment includes: hearing aids; prosthetic appliances (devices that replace or perform the function of any missing part of the body); orthotic devices (devices used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body); hospital beds and accessories; oxygen and oxygen supplies; pressure pads; volume ventilators, therapeutic ventilators, nebulizers and other equipment for respiratory care; traction equipment; walkers; canes; crutches; wheelchairs and accessories; commode chairs; toilet rails; apnea monitors; patient lifts; nutrition infusion pumps; ambulatory infusion

pumps. We will also pay for equipment servicing (labor and parts).

**B. Participating Pharmacy or Other Participating Provider of DME.** Except in an emergency, the prescription for durable medical equipment must be filled by a Participating Pharmacy or other Participating Provider.

**C. Exclusions and Limitations.** Under this section we will not pay for the following:

- Experimental appliances and devices;
- Orthotic devices prescribed solely for use during sports;
- Cranial prostheses (wigs); and
- Dental prostheses, except those made necessary due to accidental injury to sound, natural teeth and provided within 12 months of the accident, and except for dental prostheses needed in treatment of a congenital abnormality or as part of reconstructive surgery.

#### **4. Prescription and Non-Prescription Drugs.**

**A. Scope of Coverage.** We will pay for Medically Necessary FDA approved drugs requiring a prescription and non-prescription medications as outlined in the MetroPlusHealth Child Health Plus formulary. Coverage includes Medically Necessary enteral formulas (nutritional supplements) for home use (including formulas for the treatment of PKU, branched-chain ketonuria, galactosemia and homocystinuria) and modified solid food products that are low-protein or which contain modified protein for treatment of certain inherited diseases of amino acid and organic acid metabolism. We will also pay for contraceptive devices and drugs.

**B. Participating Provider and Pharmacy.** We will only pay for drugs prescribed for use outside of a hospital. Except in an emergency, the prescription must be issued by a Participating Provider or a Non-Participating Provider to whom you have been referred by your PCP with our approval. Except in an emergency, prescriptions must be filled at a Participating Pharmacy.

**C. Exclusions and Limitations.** Under this Section we will not pay for the following:



- Administration or injection of any drugs,
- Replacement of lost or stolen prescriptions,
- Prescribed drugs used for cosmetic purposes only,
- Experimental or investigational drugs unless approved by the Plan Medical Director or an External Appeal Agent,
- Non-FDA approved drugs except that we will pay for a prescription drug that is approved by the FDA for treatment of cancer when the drug is prescribed for a different type of cancer than the type for which FDA approval was obtained. However the drug must be recognized for treatment of the type of cancer for which it has been prescribed by one of these publications:
  - (a) AMA Drug Evaluations,
  - (b) American Hospital Formulary Service,
  - (c) U.S. Pharmacopoeia Drug Information, or
  - (d) A review article or editorial comment in a major peer-reviewed professional journal.
- Devices and supplies of any kind, except family planning or contraceptive devices, basal thermometers, male and female condoms, and diaphragms.
- Vitamins and other nutritional supplements, except when necessary to treat a diagnosed illness or condition.
- Prescription drugs used for purposes of treating erectile dysfunction are not covered.

5. **Home Health Care.** We will pay for up to forty (40) visits per calendar year for home health care provided by a certified home health agency that is a Participating Provider. We will pay for home health care only if you would have to be admitted to a Hospital if home care was not provided.

Home care includes one or more of the following services:

- part-time or intermittent home nursing care by or under the supervision of a registered professional nurse,
- part-time or intermittent home health aide services which consist primarily of caring for the patient,
- physical, occupational or speech therapy if provided by the home health agency, and

- medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered if the covered person had been in a Hospital.

6. **Preadmission Testing.** We will pay for preadmission testing when performed at the Hospital where surgery is scheduled to take place, if:

- reservations for a Hospital bed and for an operating room at that Hospital have been made, prior to performance of tests;
- your physician has ordered the tests; and
- surgery actually takes place within seven days of such preadmission tests.

If surgery is canceled because of the preadmission test findings, we will still cover the cost of these tests.

7. **Dental Care.**

A. **Scope of Coverage.** We will pay for emergency, preventive and routine dental services provided by a Participating Provider. You do not need your PCP's authorization for covered dental care if you seek such care from a qualified Participating Provider. Covered dental services include the following:

- Emergency treatment required to alleviate pain and suffering caused by dental disease or trauma,
- Procedures that help prevent oral disease from occurring, including but not limited to: prophylaxis (scaling and polishing the teeth) at 6-month intervals; topical fluoride application at 6-month intervals where local water supply is not fluoridated; and sealants on unrestored permanent molar teeth.
- After primary teeth erupt, routine dental examinations once within a 6-month consecutive period.
- X-rays, including full mouth x-rays at 36-month intervals and, if necessary, bitewing x-rays at 6- to 12-month intervals, or panoramic X-rays at 36-month intervals if necessary, and other X-rays as required once primary teeth erupt.

- All necessary procedures for simple extractions and other routine dental surgery not requiring hospitalization, including preoperative care and postoperative care.
- In-office conscious sedation.
- Amalgam, composite restorations and stainless-steel crowns.
- Other restorative materials appropriate for children.
- Endodontic care, including all procedures for treatment of diseased pulp chamber and pulp canals, where hospitalization is not required.
- Periodontic services, except for those services in anticipation of, or leading to, orthodontia.
- Prosthodontics, including removable complete or partial dentures with six months follow-up care and, if one or more of the following conditions are met, fixed bridges:
  - Required for replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth; or
  - Required for cleft-palate stabilization; or
  - Required, as demonstrated by medical documentation, due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis.
- Insertion of identification slips, repairs, relines and rebases in prosthodontics.
- Space maintainers, unilateral or bilateral, for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

B. **Exclusions and Limitations.** We will not pay for orthodontia services.

## 8. **Vision Care.**

A. **Scope of Coverage.** We will pay for emergency, preventive, and routine vision care. You do not need your PCP's authorization for covered vision care if you seek such care from a qualified Participating Provider of vision care services. Covered vision services include the following:

- **Vision Examinations.** We will pay for vision examinations

for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation. The vision examination may include, but is not limited to: case history; external examination of the eye or internal examination of the eye; ophthalmoscopic exam; determination of refractive status; binocular distance; tonometry tests for glaucoma; gross visual fields and color vision testing; summary findings and recommendation for corrective lenses.

- **Prescribed Lenses.** We will pay for quality standard prescription lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.
- **Frames.** We will pay for standard frames adequate to hold lenses once in any twelve (12) month period, unless required more frequently with appropriate documentation.
- **Contact Lenses.** We will pay for contact lenses only when deemed Medically Necessary.

B. **Exclusions and Limitations.** We will not pay for contact lenses that are not Medically Necessary.

9. **Hospice Services.** We will pay for a coordinated hospice program to provide non-curative medical and support services (either at home or in an inpatient hospital setting) for children (up to age 19) that have been certified by a doctor to be terminally ill with a life expectancy of six months or less.

Hospice services will cover palliative and supportive care provided to a child that meets the special needs arising out of physical, psychological, spiritual, social and economic stress which are experienced during the final stages of illness and during dying and bereavement. Additionally, family members are eligible for up to five visits for bereavement counseling.

Hospice service programs must be certified under Article 40 of the New York State Public Health Law. All services must be provided by qualified employees and volunteers of the hospice program or by qualified staff

through contractual arrangements to the extent permitted by federal and state requirements.

10. **Speech and hearing.** We will pay for speech and hearing services, including hearing aids, hearing aid batteries, and repairs. These services include hearing examination per year to determine the need for corrective action. Speech therapy required for a condition amenable to significant clinical improvement within a two-month period, beginning with the first day therapy, will be covered, when performed by audiologist, language pathologist, speech therapist, and/or otolaryngologist.

## SECTION EIGHT - ADDITIONAL INFORMATION ON HOW THIS PLAN WORKS

1. **When a Specialist Can Be Your PCP.** If you have a life threatening condition or disease or a degenerative and disabling condition or disease, you may ask that a specialist who is a Participating Provider be your PCP. We will consult with the specialist and your PCP and decide whether it would be appropriate for the specialist to serve in this capacity.
2. **Standing Referral to a Network Specialist.** If you need ongoing specialty care, you may receive a "standing referral", to a specialist who is a Participating Provider. This means that you will not need to obtain a new referral from your PCP every time you need to see that specialist. We will consult with the specialist and your PCP and decide whether a "standing referral" would be appropriate in your situation.
3. **Standing Referral to a Specialty Care Center.** If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, you may request a standing referral to a specialty care center that is a Participating Provider. We will consult with your PCP, your specialist and the specialty care center to decide whether such a referral is appropriate.

**When Your Provider Leaves the Network.** If you are undergoing a course of treatment when your provider leaves our network, then you may be able to continue to receive care from the former Participating Provider, in certain instances, for up to 90 days after you are notified by us of the provider's leaving. If you are pregnant and in your second trimester, you may be able to continue care with the former Participating Provider through delivery and postpartum care directly related to the delivery. However, in order for you to continue care for up to 90 days or through a pregnancy with a former Participating Provider, the provider must agree to accept our payment and to adhere to our procedures and policies, including those for assuring quality of care.

4. **When New Members Are In a Course of Treatment.** If you are in a course of treatment with a Non-Participating Provider when you enroll with us, you may be able to receive care from the Non-Participating Provider for up to 60 days from the date you become covered under this Contract. The course of treatment must be for a life-threatening disease or

condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if you are in the second trimester of a pregnancy when you become covered under this Contract. You may continue care through delivery and any post-partum services directly related to the delivery. However, in order for you to continue care for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept our payment and to adhere to our policies and procedures including those for assuring quality of care.

## SECTION NINE - LIMITATIONS AND EXCLUSIONS

In addition to the limitations and exclusions already described, we will not pay for the following:

1. **Care That Is Not Medically Necessary.** In general, the Plan will not cover any health care service that the Plan, in its sole judgment, determines is not medically necessary. If an External Appeal Agent certified by the State overturns the Plan's denial, however, the Plan shall cover the procedure, treatment, service, pharmaceutical product, or durable medical equipment for which coverage had been denied, to the extent that such procedure, treatment, service, pharmaceutical product, or durable medical equipment is otherwise covered under the terms of this Subscriber Contract. (For further information on external appeals, consult Section 11 of this Subscriber Contract.)
2. **Accepted Medical Practice.** You are not entitled to services which are not in accordance with accepted medical or psychiatric practices and standards in effect at the time of treatment.
3. **Care Which Is Not Provided, Authorized or Arranged by Your PCP.** Except as otherwise set forth in this Contract, you are entitled to benefits for services only when provided, authorized, or arranged by your PCP. If you choose to obtain care that is not provided, authorized or arranged by your PCP, we will not be responsible for any cost you incur.
4. **Inpatient Services in a Nursing Home, Rehabilitation Facility, or Any Other Facility Not Expressly Covered by This Contract.**
5. **Physician Services While an Inpatient of a Nursing Home, Rehabilitation Facility or Any Other Facility Not Expressly Covered by This Contract.**
6. **Experimental or Investigational Services.** In general, the Plan does not cover experimental or investigational treatments. However, the Plan shall cover an experimental or investigational treatment approved by an External Appeal Agent certified by the State. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, the Plan will only cover the costs of services required to provide treatment to you according to the design of the trial. The Plan shall not be responsible for the costs of investigational drugs or devices, the



costs of non-health care services, the costs of managing research, or costs which would not be covered under this Subscriber Contract for non-experimental or non-investigational treatments. (For further information on external appeals, consult Section 11 of this Subscriber Contract.)

7. **Cosmetic Surgery.** We will not pay for cosmetic surgery, unless medically necessary, except that we will pay for reconstructive surgery:
  - When following surgery resulting from trauma, infection or other diseases of the part of the body involved; or
  - When required to correct a functional defect resulting from congenital disease or anomaly.
8. **In Vitro Fertilization, Artificial Insemination or Other Assisted Means of Conception.**
9. **Private Duty Nursing.**
10. **Autologous Blood Donation.**
11. **Physical Manipulation Services.** We will not pay for any services in connection with the detection and correction (by manual or mechanical means) of structural imbalance; or distortion; or subluxation in the human body for the purpose of removing nerve interference and the effects thereof. This exclusion applies when the nerve interference is the result of or related to distortion, misalignment, or subluxation of or in the vertebral column.
12. **Routine Foot Care.**
13. **Other Health Insurance, Health Benefits and Governmental Programs.** We will reduce our payments under this Contract by the amount you are eligible to receive for the same service under other health insurance, health benefits plans or governmental programs. Other health insurance includes coverage by insurers, Blue Cross and Blue Shield Plans or HMOs or similar programs. Health benefit plans includes any self-insured or non-insured plan such as those offered by or arranged through employers, trustees, unions, employer organizations or employee benefit organizations. Government programs include Medicare or any other federal, state or local programs, except the Physically Handicapped Children's Program and the Early Intervention Program.

14. **No-Fault Automobile Insurance.** We will not pay for any service which is covered by mandatory automobile no-fault benefits. We will not make any payments even if you do not claim the benefits you are entitled to receive under the no-fault automobile insurance.
15. **Other Exclusions.** We will not pay for:
  - a. Sex transformation procedures; or
  - b. Custodial care.
16. **Workers' Compensation.** We will not provide coverage for any service or care for an injury, condition or disease if a claim was filed and benefits were received under a Workers' Compensation Law or similar legislation.

## SECTION TEN - PREMIUMS FOR THIS CONTRACT

1. **Amount of Premiums.** The amount of premium for this Contract is determined by us and approved by the Superintendent of Insurance of the State of New York.
2. **Your Contribution Towards the Premium.** Under New York State Law, you may be required to contribute toward the cost of your premium. We will notify you of the required contribution, if any.
3. **Grace Period.** All premiums for this Contract are due one month in advance. However, we will allow a 30-day grace period for the payment of all premiums, except the first month's. This means that, except for the first month's premium for each child, if we receive payment within 30 days of the date the payment was due, we will continue coverage under this Contract for the entire period covered by the payment. If we do not receive payment within the 30-day grace period, the coverage under this Contract will terminate as of the last day of the month when payment is due.
4. **Agreement to Pay for Services if Premium is Not Paid.** You are not entitled to any services for periods for which the premium has not been paid. If services are received during such period, you agree to pay for the services received.
5. **Change in Premiums.** If there is to be an increase or decrease in the premium or your contribution toward the premium for this Contract, we will give you at least thirty days written notice of the change.
6. **Changes in Your Income or Household Size.** You may request that we review your family premium contribution whenever your income or household size changes. You may request a review by calling us at **1-800-303-9626** or by calling the Child Health Plus Hotline at **1-800-698-4543**. At that time, we will provide you with the form and documentation requirements necessary to conduct the review. We will re-evaluate your family premium contribution and notify you of the results within 10 business days of receipt of the request and documentation necessary to conduct the review. If the review results in a change in your family premium contribution, we will apply that change no later than 40 days from receipt of the completed review request and supporting documentation.

## SECTION ELEVEN - TERMINATION OF COVERAGE

1. **For Non-Payment of Premium.** If you are required to pay a premium for this Contract, this Contract will terminate at the end of the 30 day-grace period if we do not receive your payment. For example, if your premium is due on July 1, and it is not paid by July 31, the end of the 30-day grace period, no payment will be made under this Contract for any service given to you after July 31.
2. **When You Move Outside the Service Area.** This Contract shall terminate when you cease to reside permanently in the Service Area.
3. **When You No Longer Meet Eligibility Requirements.** This Contract shall terminate as follows:
  - A. On the last day of the month in which you reach the age of 19; or
  - B. The date on which you are enrolled in the Medicaid program; or
  - C. The date on which you become covered under another health benefits program (including an insured or self-insured program through an employer group, union or other association.)
4. **Termination of the Child Health Plus Program.** This Contract shall automatically terminate on the date when the New York State law which establishes the Child Health Plus program is terminated or the State terminates this Contract or when funding from New York State for this Child Health Plus program is no longer available to us.
5. **Our Option to Terminate This Contract.** We may terminate this Contract at any time for one or more of the following reasons:
  - A. Fraud in applying for enrollment under this Contract or in receiving any services.
  - B. Such other reasons on file with the Superintendent of Insurance at the time of such termination and approved by him. A copy of such other reasons shall be forwarded to you. We shall give you no less than thirty (30) days prior written notice of such termination.
  - C. Discontinuance of the class of Contracts to which this Contract belongs upon not less than five months prior written notice of such termination.
  - D. If you do not provide the documentation we request for recertification.

6. **Your Option to Terminate This Contract.** You may terminate this Contract at any time by giving us at least one month's prior notice. We will refund any portion of the premium for this Contract that has been prepaid by you.
7. **On Your Death.** This Contract will automatically terminate on the date of your death.
8. **Benefits After Termination.** If you are totally disabled on the date this Contract terminates and you have received medical services for the illness, injury or condition which caused the total disability while covered under this Contract we will continue to pay for the illness, injury or condition related to the total disability during an uninterrupted period of total disability until the first of the following dates:
  - A date on which you are in our sole judgment, no longer totally disabled; or
  - A date twelve (12) months from the date this Contract terminates.

We will not pay for more care than you would have received if your coverage under this Contract had not terminated.

9. **Replacing Terminated Coverage.** MetroPlus Health Plan is not licensed to offer commercial insurance products other than a group managed care plan for employees of the New York City Health and Hospitals Corporation. If this contract terminates because you reach age 19 or because the Child Health Plus program ends, we will give you information about other insurance companies that sell individual health insurance policies.

## SECTION TWELVE - ACTIONS AND GRIEVANCES

### 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 later in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

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

**Your provider can ask for reconsideration:**

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

**You can file an action appeal:**

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have 90 calendar days after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services: **1-800-303-9626** if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing

**Your action appeal will be reviewed under the fast track process if:**

- If you or your doctor asks to have your appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied we will tell you and your appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track appeals can be made by phone and do not have to be followed up in writing.

### **What happens after we get your Appeal:**

- Within 15 days, we will send you a letter to let you know we are working on your appeal.
- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- Before and during the appeal you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case;
- You can also provide information to be used in making the decision in person or in writing.
- You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at **1- 800-206-8125**.

### **Timeframes for Action Appeals:**

- Standard appeals: If we have all the information we need we will tell you our decision in thirty working days from your appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
- Fast track appeals: If we have all the information we need, fast track appeal decisions will be made in 2 working days from your appeal. We will tell you in 3 work days after giving us your appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

### **If we need more information to make either for standard or fast track decision about your action appeal we will:**

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

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

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

If we do not make a decision about your appeal, the original decision against you will automatically be reversed, which means your service authorization request will be approved.

### **Aid to Continue while appealing a decision about your care:**

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

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

If your appeal you may have to pay for the cost of any continued benefits that you received.

### **External Appeals**

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the Plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; **or**



2. If you had a fast track action appeal and are not satisfied with the plan's decision you can choose to file a standard action appeal with the plan or go directly to an external appeal; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal

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

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

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

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at **1-800-303-9626** if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department at: **1-800-400-8882**
- Go to the State Insurance Department's website at [www.ins.state.ny.us](http://www.ins.state.ny.us)
- Contact the health plan at **1-800-303-9626**

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

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in three days or less. The

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

## **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: NYSDOH Office of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Coming Tower ESP, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may call the New York State Insurance Department at **1-800-342-3736** if your complaint involves a billing problem.

### **How to File a Complaint with the Plan:**

To file by phone, call Member Services at **1-800-303-9626** Monday through Saturday 8AM to 8PM. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can also submit your Complaint in writing. It should be mailed to:

**MetroPlus Health Plan**  
**50 Water Street, 7th Floor**  
**New York, NY 10004**

**Attention: Member Services**

### **What happens next:**

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters your case will be reviewed by one or more qualified health care professionals

### **After we review your complaint:**

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

### **Complaint Appeals:**

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

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

- If you are not satisfied with what we decide, you have 90 calendar days after hearing from us to file an appeal;
- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing.

### **What happens after we get your complaint appeal:**

After we get your complaint appeal we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

If we have all the information we need you will know our decision in 30 working days. If a delay would risk your health you will get our decision in 2 working days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at **1-800-206-8125**.

## SECTION THIRTEEN - GENERAL PROVISIONS

1. **No Assignment.** You cannot assign the benefits of this Contract. Any assignment or attempt to do so is void. Assignment means the transfer to another person or organization of your right to the benefits provided by this Contract.
2. **Legal Action.** You must bring any legal action against us under this Contract within twelve (12) months from the date we refused to pay for a service under this Contract. If you are bringing any legal action against us claiming personal injury, wrongful death or damage to real or personal property, you must file a Notice of Claim form within ninety (90) days as prescribed by General Municipal Law Section 50-i.
3. **Amendment of Contract.** We may change this Contract if the change is approved by the Superintendent of Insurance of the State of New York. We will give you at least 30 days written notice of any change.
4. **Medical Records.** We agree to preserve the confidentiality of your medical records. In order to administer this Contract, it may be necessary for us to obtain your medical records from hospitals, physicians or other providers who have treated you. When you become covered under this Contract, you give us permission to obtain and use such records.
5. **Who Receives Payment Under This Contract.** We will pay Participating Providers directly to provide services to you. If you receive covered services from any other provider, we reserve the right to pay either you or the provider.
6. **Notice** Any notice under this Contract may be given by United States mail, postage prepaid, addressed as follows:

If to us: MetroPlus Health Plan  
50 Water Street, 7th Floor  
New York, NY 10004

If to you: To the latest address  
provided by you on  
enrollment or official  
change-of-address form.

## PART II

### METROPLUSHEALTH INFORMATION AND SPECIAL SERVICES

#### A-ABOUT METROPLUS HEALTH PLAN

**MetroPlus Health Plan** is a health maintenance organization (an "HMO") that provides a full range of health care benefits including coverage of preventive care as well as for treatment of illness and injuries. The Plan is owned and operated by the New York City Health and Hospitals Corporation (HHC). Our participating providers include HHC's many hospitals and health centers as well as many other health care providers in your community.

MetroPlus Health Plan has its business office at the following address:

MetroPlus Health Plan  
50 Water Street, 7th Floor  
New York, NY 10004

#### B - GETTING STARTED WITH METROPLUSHEALTH

**Welcome letter, identification (ID) card and prescription card:** After your enrollment has been processed, we will send you a welcome letter giving the date on which your coverage will begin. You should receive your MetroPlus Child Health Plus identification (ID) card and prescription card shortly after your membership becomes effective. Your identification card will show your name, address, identification number, the name and telephone number of your Primary Care Provider, and your "effective date" (the date your insurance coverage begins). If any of this information is wrong or you do not receive a card in the mail, please call Member Services toll-free at **1-800-303-9626**. If you need services before your ID card arrives, you can show your provider the welcome letter. Your provider can call Member Services to confirm your coverage.

**Orientation sessions for new members:** When you join MetroPlus Health Plan, you will receive a letter inviting you to an orientation session for new members. The orientation session will take place at a convenient health care site in your community. A MetroPlusHealth Member Services Representative will tell you more about your Child Health Plus benefits and how to use the Plan. We hope you will attend.

**The baseline physical examination.** A "baseline" is a complete check-up. We recommend and pay for it. Your PCP will gather complete health information so that he or she will be able to suggest a schedule of follow-up visits as well as immunizations (shots to prevent disease). The baseline examination is also a good way to get to know your PCP. **Important Note:** If a medical problem comes up before the scheduled baseline examination, please call the PCP and make an earlier appointment.

On the first visit to the PCP, you may be asked to sign a consent form to get medical records from other health care providers. This is routine. Having complete information helps providers give the best care possible.

**Scheduling appointments.** To make or change an appointment, call your health care site. If you need to cancel or change it, please call as soon as possible. If you can, call at least 24 hours before the scheduled appointment. This way, you free up the time for someone else. When you make the call, be ready to give your name, MetroPlusHealth Child Health Plus ID Number and Medical Record Number.

## **C - MEMBER'S RESPONSIBILITIES**

We are committed to providing you with prompt, courteous, quality health care. You can help us do that by:

1. Always carrying your MetroPlusHealth Child Health Plus ID card and pharmacy benefits card.
2. Keeping your appointments and arriving for them on time. If you need to cancel an appointment, please do so at least 24 hours in advance, or as soon as possible.
3. Letting your PCP know of any change in medical status, such as a pregnancy.
4. Obtaining prior authorizations and written referrals when required.
5. Remembering to recertify each year so that your membership can continue.
6. Letting Member Services know if your address or phone number changes.

## **D - EMERGENCY AND URGENT CARE**

**In an emergency, call 911 and follow instructions or go immediately to the nearest Emergency Room.** Here are some examples of emergencies:

- Broken bones
- Breathing difficulty
- Seizures or fits
- Severe bleeding
- Danger of loss of an arm or leg
- Medicine overdose
- Loss of consciousness
- Paralysis
- Loss of speech
- Severe chest pains
- Heart attack
- Stroke

If you are pregnant, signs of an emergency may include vaginal bleeding, severe abdominal pain or cramps or your water breaking or leaking.

**NOTE:** If you have gone to an Emergency Room (whether or not it is in a Participating Hospital), you or someone else must call the Customer Services Department by the next business day at **1-800-303-9626**. We will tell your PCP about the Emergency Room visit so that you can receive the right follow-up care.

**Not Quite an Emergency--but Urgent!** An urgent problem is serious, but Emergency Room services are not required. Some examples of problems that are usually urgent rather than emergencies are:

- A bad flu
- A fever
- A bad earache

If there is an urgent problem or you are not sure how serious the problem is, call your PCP's office during business hours (8:30 a.m. to 5:30 p.m.). You will be given an urgent appointment with the PCP or a medical professional will tell you what care is necessary.

**What If the PCP's Office Is Closed?** Don't worry. Call the 24-Hour Health Care Hotline at **1-800-442-2560**. Give the operator your name, your Child Health Plus ID number, the name of your PCP and the PCP's office location. Explain the problem. We will:

- Put you in direct contact with a provider, or
- Direct you to the nearest Emergency Room.

## **E - GETTING CARE IN SPECIAL SITUATIONS**

**Referrals to a Specialist.** To see a specialist, you must first get a referral from the PCP. The PCP decides which specialist you need to see and fills out a referral form. The referral form is sent to the specialist by fax or mail or you may take a copy of the form to the specialist. Your PCP may help you make an appointment



with the specialist. Section 7 of the Subscriber Contract (Part I of this booklet) gives information about when a specialist can be your PCP and about standing referrals to specialists and specialty care centers.

If we do not have a specialist in the MetroPlusHealth network who can give you the care you need, we will find one for you outside the network. Before you can see the specialist, your doctor must ask MetroPlusHealth for a referral. If you need to see a specialist right away, because you have an emergency, your doctor does not have to call for a referral.

To get the referral, your doctor must give us some information. Once we get all this information, we will decide within 3 work days if you can see the out-of-network specialist. But, we will never take longer than 14 days from the date we got your request to make that decision. You or your doctor can ask for a fast track review if your doctor feels that a delay will cause serious harm to your health. In that case, we will decide and get back to you in 3 work days.

If you disagree with the MetroPlusHealth decision, you may file an appeal (see page 28 of this handbook for how to do this). You can also call the MetroPlusHealth Customer Services at **1-800-303-9626**.

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

**Self-Referral for Ob/Gyn Services.** You do not need a referral from the PCP to make an appointment with a MetroPlusHealth Ob/Gyn provider. This provider may be an obstetrician, gynecologist, nurse practitioner or licensed midwife.

**HIV Testing and Counseling.** All HIV testing and counseling is confidential. If you want to be tested, you can visit a MetroPlusHealth provider. Or, you can go to a New York City or New York State anonymous testing program where only you will know your test results. Either way, you do not need a referral.

If **you are pregnant**, you and your baby may be eligible for Medicaid. We will tell you how to find out if this is the case. Call Member Services at **1-800-303-9626**.

**Mastectomy related services.** If you have a mastectomy, you can receive mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications

resulting from mastectomy (including lymphedema). For more information, call Member Services at **1-800-303-9626**.

## **F - UTILIZATION REVIEW**

Utilization review is the process for deciding whether care is medically necessary and will be authorized or paid for by MetroPlusHealth. Our UR staff is available 8:30am to 5:00pm Monday through Friday.

You can call Member Services at **1-800-303-9626** or you can send your request for Utilization Review by Fax to **212-908-8521**. A Member Services Representative will answer any questions you have about the process and will transfer your call to the Utilization Review (UR) Department, if needed.

We have a 24-Hour Health Care Hotline number **1-800-442-2560** to use if you need immediate assistance with a medical problem. UR staff will respond to your message on the next business day.

**Prior authorization:** The following services must be approved in advance (pre-authorized) by either your PCP or MetroPlusHealth, as indicated.

PCPs can authorize referrals for:

- Specialty care.
- Durable medical equipment.
- Radiology (including MRI, CT, etc.)
- Laboratory services.
- Home care.
- Hearing check/audiology.

PCPs must get prior authorization from MetroPlusHealth for:

- A standing referral to a specialist.
- An elective hospital admission.
- An elective outpatient procedure.
- A referral to a provider who is not in the MetroPlusHealth network.

When prior authorization is requested, a UR decision will be made and communicated to you (or a designated representative) and your health care provider within three business days after MetroPlusHealth receives the information needed to make the decision.

**Concurrent UR:** When authorization is requested to continue or expand authorized treatment that you are currently receiving, a decision will be made and communicated to your health care provider by phone and in writing within one business day after we receive the information needed to make the decision.

**After service delivery:** When utilization review concerns payment for services already received, a decision will be made and communicated to the provider in writing within thirty days after all necessary information is received.

**Failure by MetroPlusHealth to make an initial UR determination within the required time period** will be considered an adverse determination subject to appeal.

**Notice of adverse determination:** If MetroPlusHealth decides that the services for which authorization or payment is requested are or were not medically necessary, we will state the reasons for the decision and explain how you or your provider can appeal if not satisfied.

**Reconsideration and appeals:** If we decide not to authorize services that your health care provider recommends and we have not talked with that provider, the provider can ask us to reconsider the decision. The reconsideration will be done within one business day of the request. Adverse determinations can be appealed. See Section 11 in Part I of this booklet (the Subscriber Contract) for information about MetroPlusHealth UR appeals and New York State external appeals.

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

## **G - GETTING HELP FROM MEMBER SERVICES**

MetroPlusHealth Member Service Representatives are here to help you. If you have a problem, complaint, or just need information, follow these steps:

1. Call Member Services Monday through Saturday from 8 AM - 8 PM using the toll-free number **1-800-303-9626**. A Member Services Representative will help solve the problem or provide the information you need.
2. You may also call outside of business hours with a Member Service issue that you think can't wait. A machine will answer your call and tell you what information to provide. A Member Services Representative will call you back in person the next business day.
3. If you have a problem that is not resolved by calling Member Services, you may file a formal complaint with us or complain to the New York State Department of Health. (See Section 11 for information about how to do this.)

While our Member Service Representatives will always try to help you resolve your problems and concerns, you should always contact your PCP first about any medical problems.

## **H - HELP FOR MEMBERS WHO DO NOT SPEAK ENGLISH AND THOSE WHO HAVE HEARING OR VISION IMPAIRMENTS**

In addition to English, this booklet is available in Spanish. It is also available in Braille and on audiotape.

Our provider directory lists the languages spoken by providers in addition to English. Interpreter services are available at many of our provider sites. We have Member Service Representatives who can help you in Spanish, Haitian Creole, Russian and Chinese. If necessary, we will arrange for interpreter services through the ATT Language Bank.

Hearing-impaired members with access to a TDD machine may call **1-800-881-2812** with questions.

## **I - FRAUD PREVENTION**

You can help prevent health care fraud. Protect your MetroPlus Health Plan identification card as you would a credit card. Be careful about giving your ID number to strangers. Someone could use your card to commit fraud. If your ID card is lost or stolen, call MetroPlusHealth Member Services right away. Also, if you get a bill for services that should be paid for by MetroPlusHealth, call Member Services.

## **J - OFFICE OF PROFESSIONAL MEDICAL CONDUCT**

You can call the New York State Office of Professional Medical Conduct if you have questions about your provider's license. Call toll free **1-800-663-6114** Monday through Friday, between 8:30 a.m. and 5 p.m.

## **K - MEMBER INPUT INTO PLAN POLICIES AND PROCEDURES**

We welcome your ideas on how to improve MetroPlus Health Plan. To give us your suggestions, please call **1-800-303-9626** or write to us at:

MetroPlus Health Plan  
50 Water Street, 7th Floor  
New York, NY 10004  
Attention: Member Services Department

## **L - PROVIDER PAYMENT METHODS**

MetroPlusHealth pays for services in two ways. For primary care, we pay a fixed amount each month for each MetroPlusHealth member. The amount is not affected by how many times you visit your PCP or how many primary care services you receive. For all other services, we are billed by the provider for the services actually given and we pay at rates set in our contracts. We do not use withholds, profit sharing, or other payment methods that may encourage doctors to provide fewer services.

## **M - OTHER INFORMATION AVAILABLE TO YOU ON REQUEST**

The following information is available to you. To request it, please call Member Services at **1-800-303-9626**.

- Names and addresses of MetroPlusHealth officers and directors.
- A copy of our most recent annual financial statement.
- Department of Insurance consumer complaint information.
- MetroPlusHealth confidentiality protection procedures.
- A list of medicines we will pay for.
- A description of what we do to ensure quality care.
- A description of how we decide to approve any experimental or investigational drugs, devices or treatments.
- Information on the MetroPlusHealth hospital affiliations of our health care providers.

- MetroPlusHealth written medical standards of care for a particular sickness or medical problem (upon written request).
- Application procedures and minimum qualifications for health care providers to become MetroPlusHealth providers.
- Additional information on advance directives.

## **N - METROPLUSHEALTH MEMBERS' BILL OF RIGHTS**

The MetroPlus Health Plan Member Bill of Rights gives members who are receiving care at any participating health center the following rights:

1. The right to be treated with consideration, dignity and respect, regardless of your physical and emotional condition.
2. The right to get complete information regarding diagnosis, treatment and outcome in a language that is easily understood by you.
3. The right to be informed of the name, title and function of anyone involved in your care, as well as information about their professional qualifications.
4. The right to receive necessary information in order to give informed consent before the beginning of any procedure or treatment (except in emergency situations when informed consent cannot be obtained).
5. The right to refuse treatment to the extent permitted by law, and to be informed of any medical problems you may experience from lack of treatment.
6. The right to receive necessary emergency medical care when you arrive at the emergency room.
7. The right to receive confidential care and treatment and to have all your medical records remain private except as provided by law.
8. The right to be told by a doctor, or his or her representative, of any special health care needs you may have after being discharged or transferred.
9. The right to refuse to take part in research and/or any experimental treatment as part of your care or treatment unless you have full knowledge and agree.
10. The right to receive treatment without discrimination as to age, race, color, religion, gender, sexual orientation or national origin.
11. The right to voice or file a written grievance without fear of reprisal.
12. The right to have decisions carried out as you request in an Advance Directive.

## Important Phone Numbers

For help from **MetroPlusHealth Member Services**, call **1-800-303-9626 (TDD: 1-800- 881-2812)**

If you have a question or complaint or you need help of other kinds, call MetroPlusHealth Member Services (toll free) 8:00 a.m. to 8:00 p.m. Monday through Saturday.

### **Health Care During Business Hours (8:30 a.m. to 5:30 p.m., Monday-Friday)**

To make or change an appointment, or if you have questions about your health or medical treatment, call your health care provider. Write your providers phone numbers here:

<b>Name</b>	<b>Phone Number</b>
<b>PCP:</b>	
<b>OB/GYN:</b>	
<b>Other:</b>	
<b>Other:</b>	

### **Outside normal business hours, call the 24-Hour Health Care Hotline: 1- 800-442-2560**

If you need health care after hours or on weekends, call our 24-Hour Health Care Hotline (toll free). The Hotline staff will put you in touch with your PCP or, if your PCP cant be reached, another MetroPlusHealth provider who works with your PCP and can help you.

### **Emergency Services**

In an emergency, *call 911 and follow instructions or go to the nearest emergency room. Emergency Condition and Emergency Services* are defined on page 2.

## **MetroPlusHealth Utilization Review**

For review of a decision that treatment is not medically necessary, call Member Services at **1-800-303-9626**. A Member Services Representative will answer any questions you have about the process and will transfer your call to the Utilization Review (UR) Department, if needed.

**New York State Department of Health Complaint Hotline: 1-800-206-8125**





Dear MetroPlusHealth Member:

Like many people today, you may be wondering what happens to the personal information about you that your health plan receives. The following *Notice of Privacy Practices* tells you about your privacy rights, the personal information MetroPlus Health Plan collects, what we do with that information, and the steps we take to keep it confidential and secure.

Our company's commitment to customer privacy is not new. MetroPlusHealth members have trusted us with their personal information for as long as we have been in business. We value that trust and take seriously our responsibility to protect your privacy.

Please read the notice carefully. No response is required. If you have questions, however, we would be happy to answer them. Please call our Member Services Department at **1-800-303-9626** (TTY 1-800-881-2812).

Sincerely,

MetroPlus Health Plan



Effective July 19, 2022

MetroPlus Health Plan  
50 Water Street, 7th Floor  
New York, NY 10004

Website: [www.metroplus.org](http://www.metroplus.org)

General Phone: 1-800-303-9626

TTY: 711

E-mail: [PrivacyOfficer@metroplus.org](mailto:PrivacyOfficer@metroplus.org)

## Your Information.

## Your Rights.

## Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

### Your Rights

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

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#### Get a copy of your health and claims records

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

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#### Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

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#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
  - We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
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## Your Rights (continued)

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|---|--|
| <b>Ask us to limit what we use or share</b>                   | <ul style="list-style-type: none"><li>• You can ask us <b>not</b> to use or share certain health information for treatment, payment, or our operations.</li><li>• We are not required to agree to your request, and we may say “no” if it would affect your care</li></ul>   |
| <hr/>   |  |
| <b>Get a list of those with whom we’ve shared information</b> | <ul style="list-style-type: none"><li>• You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.</li><li>• We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.</li><li>• To ask for confidential communications, call our Member Services Department at 1-800-303-9626 (TTY: 711). Requests to change or modify this type of confidential communication request must be made in writing to the address listed below.</li></ul> |
| <hr/>   |  |
| <b>Get a copy of this privacy notice</b>                      | <ul style="list-style-type: none"><li>• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. You may get a paper copy of this notice at any time by calling our Member Services Department at 1-800-303-9626 (TTY: 711).</li></ul>   |
| <hr/>   |  |
| <b>Choose someone to act for you</b>                          | <ul style="list-style-type: none"><li>• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.</li><li>• We will make sure the person has this authority and can act for you before we take any action.</li></ul>  |
| <hr/>   |  |
| <b>File a complaint if you feel your rights are violated</b>  | <ul style="list-style-type: none"><li>• You can complain if you feel we have violated your rights by contacting us using the information on page 1.</li><li>• You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting <a href="http://www.hhs.gov/ocr/privacy/hipaa/complaints/">www.hhs.gov/ocr/privacy/hipaa/complaints/</a>. We will not retaliate against you for filing a complaint.</li></ul>   |
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## Your Rights (continued)

### Former Members

- If your membership with MetroPlusHealth ends, your Information will remain protected in accordance with our policies and procedures for current members.

## Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

### In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.

- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

### In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

## Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

### Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Health Related Products or Programs: MetroPlusHealth may provide you information on medical treatments, programs products and services.

**Example:** A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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## Our Uses and Disclosures (continued)

The information provided to you is subject to any limits imposed by the law.

- Reminders: MetroPlusHealth may use and disclose PHI about you (for example, by calling or texting you or sending you a letter) to remind you of an appointment for treatment or that it's time for you to schedule an appointment for a regular check-up or immunization, or to provide information about treatment alternatives ("choices") or other health-related benefits and services that may be of interest to you.

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### Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

***Example:** We use health information about you to develop better services for you. MetroPlusHealth's Quality Management Department may use your health information to help improve the quality of the Plan's programs, data and business processes. As an example, your medical record may be reviewed by our quality management staff or contracted nurse reviewers to evaluate the quality of care provided to you and all Plan members.*

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## Our Uses and Disclosures (continued)

**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Administer your plan**

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

***Example:** Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

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**Pay for your health services**

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

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

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**Provide quality care and efficient delivery of services**

MetroPlusHealth participates in the health information exchange operated by Healthix. Healthix is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. This Notice is to inform our patients that as part of participation in Healthix, MetroPlusHealth electronically sends/uploads our patients' Protected Health Information to Healthix.

Additionally, certain staff at MetroPlusHealth are authorized to access patient information through Healthix subject to applicable consent rules. Consent to access Healthix is normally granted on an organization-by-organization basis. However, patients have the option of denying access to all organizations in Healthix. If you are interested in denying consent for all Healthix organizations to access your Protected Health Information, you may do so by visiting Healthix's website at [www.healthix.org](http://www.healthix.org) or calling Healthix at 877-695-4749. Information in Healthix about patients comes from places that have provided medical care or through health insurance (claims) information. These data sources may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program and other organizations that exchange health information electronically. An updated list of these data sources is available from Healthix. Patients can obtain an updated list at any time by visiting [www.healthix.org](http://www.healthix.org) or by calling 1-877-695-4749.

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## Our Uses and Disclosures (continued)

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<b>Help with public health and safety issues</b>	We can share health information about you for certain situations such as: <ul style="list-style-type: none"><li>○ Preventing disease</li><li>○ Reporting adverse reactions to medications</li><li>○ Reporting suspected abuse, neglect, or domestic violence</li><li>○ Preventing or reducing a serious threat to anyone’s health or safety.</li></ul>
<b>Perform Research</b>	We can use or share your information for health research.
<b>Comply with the law</b>	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.
<b>Address workers’ compensation, law enforcement, and other government requests</b>	We can use or share health information about you: <ul style="list-style-type: none"><li>○ For worker’s compensation claims</li><li>○ For law enforcement purposes or with a law enforcement official</li><li>○ With health oversight agencies authorized by law</li><li>○ For special government functions such as military, national security, and presidential protective services</li></ul>
<b>Respond to lawsuits and legal action</b>	We can share health information about you in response to a court or legal administrative order, or in response to a subpoena
<b>New York State laws on disclosures for certain types of information</b>	MetroPlusHealth must comply with additional New York State laws that have a higher level of protection for personal information, particularly information relating to HIV/AIDS status or treatment; mental health; substance use disorder; and family planning.

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## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

This notice is effective as of July 19, 2022.

### Privacy Officer Contact Information

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

#### Customer Services – MetroPlus Health Plan

50 Water Street, 7th Floor

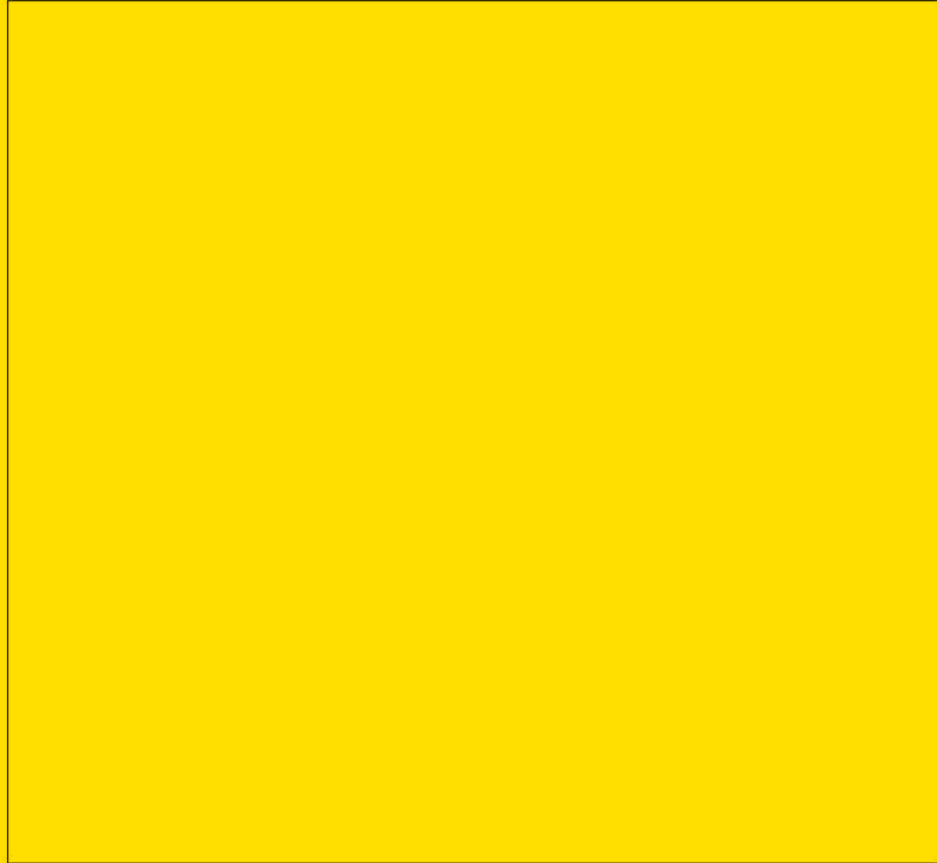
New York, NY 10004

- **General Phone:** 1-800-303-9626, 7 days per week 8:00 a.m. to 8:00 p.m.
- **Medicare Members:** 1-866-986-0356, 7 days per week, 8:00 a.m. to 8:00 p.m.
- **TTY:** 711
- **E-mail:** [PrivacyOfficer@metroplus.org](mailto:PrivacyOfficer@metroplus.org)






50 Water St., 7<sup>th</sup> Floor • New York, NY 10004



### **MetroPlusHealth Customer Services:**


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 **800.303.9626 (TTY: 711)**  
**After Hours: 800.442.2560**

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 **metroplus.org**

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 **Hours Of Operation:**  
**Monday to Friday, 8am - 8pm |**  
**Saturday, 9am - 5pm**