Member Handbook, and Other Important Documents

This handbook is revised for October, 2015.

This handbook will tell you how to use your Managed Care Plan. Put this handbook where you can find it when you need it.

Member Services: 1-800-650-4359 TTY: 1-800-662-1220

SERVICE AUTHORIZATION AND APPEAL CHANGES EFFECTIVE 6/1/2018

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(EHBO)

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NOTICE OF NON-DISCRIMINATION

Excellus BlueCross BlueShield complies with Federal civil rights laws. Excellus BlueCross BlueShield does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Excellus BlueCross BlueShield provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Excellus BlueCross BlueShield** at 1-800-650-4359. For TTY/TDD services, call 1-800-662-1220.

If you believe that Excellus BlueCross BlueShield has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Excellus BlueCross BlueShield by:

Mail:	Advocacy Department, P.O. Box 4717, Syracuse, NY 13221
Phone:	1-800-614-6575 for TTY/TDD services, call 1-800-662-1220
Fax:	1-315-671-6656
In person:	165 Court Street, Rochester, NY 14647, OR 333 Butternut Drive, Syracuse, NY 13214

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-800-650-4359, TTY/TDD 1-800-662-1220.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-650-4359, TTY/TDD 1-800-622-1220.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-650-4359, TTY/TDD 1-800-662-1220.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-650-4359 (رقم هاتف الصم والبك TTY/TDD 1-800-662-1220.	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니 1-800-650-4359, TTY/TDD 1-800-662-1220.번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-650-4359 (телетайп: TTY/TDD 1-800-662-1220).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-650-4359, TTY/TDD 1-800-662-1220.	Italian
ATTENTION : Si vous parlez français, des serv\ices d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-650-4359, TTY/TDD 1-800-662-1220.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-650-4359, TTY/TDD 1-800-662-1220.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-650-4359, TTY/TDD 1-800-662-1220.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-650-4359, TTY/TDD 1-800-662-1220.	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-650-4359, TTY/TDD 1-800-662-1220.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন ১ 1-800-650-4359, TTY/TDD 1-800-662-1220.	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-650-4359, TTY/TDD 1-800-662-1220.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-650-4359, TTY/TDD 1-800-662-1220.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کری 1-800-650-4359, TTY/TDD 1-800-662-1220.	Urdu

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Welcome to HMOBlue Option's Medicaid Managed Care Program

We are glad that you enrolled in HMOBlue Option. This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call Member Services at 1-800-650-4359.

How Managed Care Works

HMOBlue Option, Our Providers, and You

- You may have heard about the changes in health care. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through HMOBlue Option.
- HMOBlue Option has a contract with the State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call Member Services at 1-800-650-4359 to get a copy or visit our website at www.excellusbcbs.com.
- When you join HMOBlue Option, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.
- Your PCP is available to you everyday, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can "self-refer" to certain doctors for some services. See pages 8-9 for details.
- You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:
    - getting care from several doctors for the same problem.
    - getting medical care more often than needed.
    - using prescription medicine in a way that may be dangerous to your health.
    - allowing someone other than yourself to use your plan ID card.

Confidentiality

We respect your right to privacy. HMOBlue Option recognizes the trust needed between you, your family, your doctors and other care providers. HMOBlue Option will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be HMOBlue Option, your Primary Care Provider and other providers who give you care and you authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider or your Health Home Care Manager, if you have one. HMOBlue Option staff have been trained in keeping strict member confidentiality.

How To Use This Handbook

This handbook will help you, when you join a managed care plan. It will tell you how your new health care system will work and how you can get the most from HMOBlue Option. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

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

When you have a question, check this Handbook or call our Member Services at 1-800-650-4359. You can also call the managed care staff at your local Department of Social Services.

You can also call the New York Medicaid Choice Help Line at 1-800-505-5678.

Help From Member Services

There is someone to help you at Member Services. Please call Member Services at 1-800-650-4359 or TTY at 1-800-662-1220. You can reach us Mondays through Fridays from 8 a.m. to 6 p.m.
You can call 1-800-650-4359 or TTY 1-800-662-1220 after hours to reach someone or you can leave a message for a Member Services representative to call you back the next business day during normal business hours.

- You can call Member Services to get help **anytime you have a question**. You may call us to choose or change your Primary Care Provider (PCP for short), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby or ask about any change that might affect you or your family's benefits.
- If you are or become pregnant, your child will become part of HMOBlue Option on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.
- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.
- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with communications devices. Also, we have services like:
    - TTY Machine (Our TTY phone number is 1-800-662-1220)
    - Information in Large Print
    - Case Management

- Help in Making or Getting to Appointments
- Names and Addresses of providers who specialize in your disability

- **If you or your child is getting care in your home now**, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

Your Health Plan ID Card

After you enroll, we'll send you a Welcome Letter. Your HMOBlue Option ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (primary care provider's) name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong, on your HMOBlue Option ID card, call us right away. Your ID card does not show that you have Medicaid or that HMOBlue Option is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that HMOBlue Option does not cover.

PART 1
First Things You Should Know

How To Choose Your Primary Care Provider (PCP)

You may have already picked your Primary Care Provider (PCP) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for you or your family, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you.

Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can check to see if you already have a PCP or help you choose a PCP.

Our provider directory has a list of all the doctors, clinics, hospitals, labs, and others who work with HMOBlue Option. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP. You can also get a list of providers on our website at www.excellusbcbs.com.

You may want to find a doctor:

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

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

We also contract with **FQHCs** (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with. Just check our provider directory for a list of FQHCs or call Member Services at 1-800-650-4359 for help.

In almost all cases, your doctors will be HMOBlue Option providers. There are four instances when you can still **see another doctor that you had before you joined HMOBlue Option.** In these cases, your provider must agree to work with HMOBlue Option**.**

You can continue to see your doctor if:

- You are more than 3 months pregnant when you join HMOBlue Option and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.

- At the time you join HMOBlue Option, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join HMOBlue Option, you are being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to 2 years.
- At the time you join HMOBlue Option, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse or attendant, and the same amount of home care, for at least 90 days.

HMOBlue Option must tell you about any changes to your home care before the changes take effect.

If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to **choose a specialist to act as your PCP (primary care provider)**. Your current PCP must submit this request to us in writing. If our Medical Director, your current PCP, and the specialist agree, and our Medical Director approves your treatment plan, we will approve the specialist as your PCP. Contact Member Services at 1-800-650-4359 if you have questions.

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

If your **provider leaves HMOBlue Option,** we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with HMOBlue Option during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-650-4359.

How to Get Regular Health Care

Regular health care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.

Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your care must be **medically necessary.** The services you get must be needed:

1. to prevent, or diagnose and correct what could cause more suffering, or
2. to deal with a danger to your life, or
3. to deal with a problem that could cause illness, or
4. to deal with something that could limit your normal activities.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If ever you can't keep an appointment, call to let your PCP know.

As soon as you choose a PCP, call to make a first appointment. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

If you need care before your first appointment, call your PCP's office to explain your concern. He or she will give you an earlier appointment. You should still keep the first appointment to discuss your medical history and ask questions.

Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for an appointment:**

- **adult baseline and routine physicals:** within 12 weeks
- **urgent care:** within 24 hours
- **non-urgent sick visits:** within 3 days
- **routine, preventive care:** within 4 weeks
- **first pre-natal visit:** within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
- **first newborn visit:** within 2 weeks of hospital discharge
- **first family planning visit:** within 2 weeks
- **follow-up after a mental health/substance abuse ER or inpatient visit:** 5 days
- **non-urgent mental health or substance abuse visit:** 2 weeks.

How To Get Specialty Care and Referrals

If you need care that your PCP cannot give, he or she will REFER you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are HMOBlue Option providers. Talk with your PCP to be sure you know how referrals work.

If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.

There are some treatments and services that your PCP must ask HMOBlue Option to approve ***before*** you can get them. Your PCP will be able to tell you what they are.

- If you are having trouble getting a referral you think you need, contact Member Services at 1-800-650-4359.
- If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan. This is called an **out-of-network referral**. Your PCP or plan provider must ask HMOBlue Option for approval ***before*** you can get an out-of-network referral. If your PCP or plan provider refers you to a provider outside our network, you are not responsible for any of the costs except any copayments as described in this handbook.
- To request to see a specialist outside HMOBlue Option's network, have your doctor contact Member Services at 1-800-650-4359.
    - Sometimes we may not approve an out-of-network referral because we have a provider in HMOBlue Option that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page 25 to find out how.

- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from HMOBlue Option provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See Page 25 to find out how.

- You may access providers in HMOBlue Option's entire approved network as long as you are referred to an in-network provider by your PCP, other in-network specialist, or by HMOBlue Option.
- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- *If you have a long-term disease or a disabling illness that gets worse over time, your* PCP may be able to arrange for:
  - your specialist to act as your PCP; or
  - a referral to a specialty care center that deals with the treatment of your problem. You can also call Member Services at 1-800-650-4359 for help in getting access to a specialty care center.

Get These Services From HMOBlue Option Without A Referral

Women's Health Care:

You do not need a referral from your PCP to see one of our providers if:

- you are pregnant,
- you need OB/GYN services,
- you need family planning services,
- you want to see a mid-wife,
- you need to have a breast or pelvic exam.

Family Planning

You can get the following family planning services:

- advice about birth control,
- birth control prescriptions,
- male and female condoms,
- pregnancy tests,
- sterilization, or
- an abortion.

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

You *do not need a referral* from your PCP to get these services. In fact, you can choose where to get these services. You can use your HMOBlue Option ID card to see one of HMOBlue Option's family planning providers. Check the plan's Provider Directory or call Member Services at 1-800-650-4359 for help in finding a provider.

Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or call Member Services at 1-800-650-4359 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

HIV and STI Screening

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your regular health care.

- You can get an HIV or STI test any time you have an office or clinic visit.
- You can get HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with any family planning providers. If you want an HIV or STI test, but *not as part of a family planning service*, your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of HMOBlue Option's providers, you can use your Medicaid card to see a family planning provider outside HMOBlue Option. For help in finding either a HMOBlue Option provider or a Medicaid provider for family planning services, call Member Services at 1-800-650-4359.
- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

Some tests are "rapid tests" and the results are ready while you wait. The provider who gives you the test will explain the results and arrange for follow-up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

Eye Care

The covered benefits include the needed services for an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every 2 years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period. You just choose one of our participating providers.

New eyeglasses (with Medicaid approved frames) are usually provided once every 2 years. New lenses may be ordered more often, if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can't be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health – (Mental Health and Substance Use)

We want to help you get the mental health and drug or alcohol abuse services that you may need. If at any time you think you need help with mental health or substance use, you can see behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services. You do not need a referral from your PCP.

Smoking Cessation

You can get medication, supplies and counseling if you want help to quit smoking. You do not need a referral from your PCP to get these services.

Maternal Depression Screening

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening for depression during pregnancy and for up to a year after your delivery.

Emergencies

You are always covered for emergencies.

An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms.

An emergency would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away. Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting
- drug overdose

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

Non-emergencies may also be family issues, a break up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

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

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

If you are not sure, call your PCP or HMOBlue Option.

Tell the person you speak with what is happening. Your PCP or Member Services representative will:

- tell you what to do at home,
- tell you to come to the PCP's office, or
- tell you to go to the nearest emergency room.

If you are **out of the area,** when you have an emergency:

- Go to the nearest emergency room.

REMEMBER:

You do not need prior approval for emergency services. Use the emergency room **only** if you have an **Emergency**.

The Emergency room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or Member Services at 1-800-650-4359.

Urgent Care

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

- This could be a child with an ear ache who wakes up in the middle of the night and won't stop crying.
- This could be the flu or if you need stiches
- It could be a sprained ankle, or a bad splinter you can't remove.

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-650-4359. Tell the person who answers what is happening. They will tell you what to do.

Care Outside of the United States

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

We Want To Keep You Healthy

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

- Classes for you and your family
- Stop-smoking classes
- Pre-natal care and nutrition
- Grief / Loss support
- Breast-feeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually Transmitted Infection (STI) Testing & Protecting Yourself from STIs
- Domestic Violence Services

Call Member Services at 1-800-650-4359 or visit our website at www.excellusbcbs.com to find out more and get a list of upcoming classes.

PART 2
Your Benefits And Plan Procedures

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

Benefits

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. HMOBlue Option will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services, including those you can get from within the HMOBlue Option and some that you can choose to go to any Medicaid provider of the service. Please call Member Services at 1-800-650-4359 if you have any questions or need help with any of the services below.

Services Covered By HMOBlue Option

You must get these services from the providers who are in HMOBlue Option. All services must be medically necessary and provided or referred by your PCP (Primary Care Provider). Please call Member Services at 1-800-650-4359 if you have any questions or need help with any of the services below.

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye/hearing exams

Preventive Care

- well-baby care
- well-child care
- regular check-ups
- shots for children from birth through childhood
- access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- smoking cessation counseling
- access to free needles and syringes
- HIV education and risk reduction

Maternity Care

- pregnancy care
- doctors / mid-wife and hospital services
- newborn nursery care
- screening for depression during pregnancy and up to a year after delivery

Home Health Care

- must be medically needed and arranged by HMOBlue Option
- one medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women
- at least 2 visits to high-risk infants (newborns)
- other home health care visits as needed and ordered by your PCP/specialist

Personal Care/Home Attendant/Consumer Directed Personal Assistance Service (CDPAS)

- Must be medically needed and arranged by HMOBlue Option.
- Personal Care/Home Attendant –Help with bathing, dressing and feeding and help with preparing meals and housekeeping.
- CDPAS – Help with bathing, dressing and feeding, help preparing meals and housekeeping, plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you.
- If you want more information contact Member Services at 1-800-650-4359.

Personal Emergency Response System (PERS)

- This is an item you wear in case you have an emergency.
- To qualify and get this service you must be receiving personal care/home attendant or CDPAS services.

Adult Day Healthcare Services

- Must be recommended by your Primary Care Provider (PCP).
- Provides health education, nutrition, nursing and social services, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for necessary dental and specialty care.

AIDS Adult Day Health Care Services

- Must be recommended by your Primary Care Provider (PCP).
- Provides general medical and nursing care, substance abuse supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/health promotion activities.

Therapy for Tuberculosis

- This is help taking your medication for TB and follow up care

Hospice Care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death.
- Must be medically needed and arranged by HMOBlue Option.
- Provides support services and some medical services to patients who are ill and expect to live for one year or less.
- You can get these services in your home or in a hospital or nursing home.

Children under age twenty-one (21) who are getting hospice services can also get medically needed curative services and palliative care.

If you have any questions about these services, you can call Member Services at 1-800-650-4359.

Dental Care

HMOBlue Option believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, Inc., 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 Get Dental Services:

Your dental benefits are managed by Healthplex, Inc. who has participating dentists who specialize in general dentistry, pediatric dentistry, oral surgery and gum disease. Your dental care must be provided by dentists in the Healthplex network. You will receive a Healthplex Dentist Directory in the mail. Healthplex will assign you a participating primary dentist (PCD) based on your address. If you already have a dentist that you want to continue to see, you need to call Healthplex to find out if your dentist is participating with them. If you need to see a dental specialist, your primary dentist (PCD) must make a referral to a dental specialist for you.

- If you need to find a dentist or change your dentist, please call Healthplex at 1-800-468-9868 or please call HMOBlue Option at 1-800-650-4359. Member Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card.
- When you visit your dentist, you should show your plan ID card.

You can also go to a dental clinic that is run by an academic dental center without a referral. Please call Healthplex at 1-800-468-9868 for more help.

Orthodontic Care

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

Vision Care

- services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- eye exams, generally every 2 years, unless medically needed more often
- glasses (new pair of Medicaid approved frames every 2 years, or more often if medically needed)
- low vision exam and vision aids ordered by your doctor
- specialist referrals for eye diseases or defects

Pharmacy

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Emergency Contraception (6 per calendar year)
- Medical and surgical supplies

A pharmacy co-payment may be required for some people, for some medications and pharmacy items. There are no co-pays for the following consumers/services:

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

Prescription Item	**Co-payment amount**	**Co-payment details**
Brand-name prescription drugs	$3.00	One co-pay charge for each new prescription and each refill.
Generic prescription drugs	$1.00	One co-pay charge for each new prescription and each refill.
Over-the-counter medications, (e.g., for smoking cessation and diabetes)	$0.50 per medication	One co-pay charge for each new prescription and each refill.

- There is a co-payment for each new prescription *and* each refill.
- If you have a co-pay, you are responsible for a maximum of $200 per calendar year.
- If you transferred plans during the calendar year, keep your receipts as proof of your co-payments or you may request proof of paid co-payments from your pharmacy. You will need to give a copy to your new plan.
- Certain medications may require that your doctor get prior authorization from us before writing your prescription. Your doctor can work HMOBlue Option to make sure you get the medications that you need. Learn more about prior authorization later in this handbook.
- You have a choice in where you fill your prescriptions. You can go to any Pharmacy that participates with our plan or you can fill your prescriptions by using our mail order pharmacy. For more information on your options, please contact Member Services at 1-800-650-4359.

Hospital Care

- inpatient care
- outpatient care
- lab, x-ray, other tests

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services**.
- For more about emergency services, see pages 9-10.

Specialty Care

Includes the services of other practitioners, including

- occupational, physical and speech therapists - Limited to twenty (20) visits per therapy, per calendar year, except for children under age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury.
- audiologists
- midwives
- cardiac rehabilitation
- Podiatrists if you are diabetic

Residential Health Care Facility Care (Nursing Home)

- includes short term, or rehab, stays and long term care;
- must be ordered by a physician and authorized by HMOBlue Option;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology.

If you are in need of long term placement in a nursing home, your local department of social services must determine if you meet certain Medicaid income requirements. HMOBlue Option and the nursing home can help you apply.

You must get this care from a nursing home that is in HMOBlue Option's provider network. If you choose a nursing home outside of HMOBlue Option's network, you may have to transfer to another plan. Call New York Medicaid Choice at 1-800-505-5678 for help with questions about nursing home providers and plan networks.

Call 1-800-650-4359 for help finding a nursing home in our network.

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. These services include:

Mental Health Care

- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services if you are in a community home or in family-based treatment
- Continuing day treatment
- Personalized Recovery Oriented Services
- Assertive Community Treatment Services
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid, including Methadone Maintenance treatment
- Residential Substance Use Disorder Treatment
- Outpatient alcohol and drug treatment services Detox services

Harm Reduction Services

If you are in need of help related to substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. HMOBlue Option covers services that may help reduce substance use and other related harms. These services include:

- A plan of care developed by a person experienced in working with substance users.
- Individual supportive counseling that assists in achieving your goals.
- Group supportive counseling in a safe space to talk with others about issues that affect your health and well-being.
- Counseling to help you with taking your prescribed medication and continuing treatment.
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you.

To learn more about these services, call Member Services at 1-800-650-4359 or TTY 1-800-662-1220.

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics / Orthotics
- Court Ordered services
- Case Management
- Help getting social support services
- FQHC
- Family Planning
- Services of a Podiatrist for children under 21 years old

Benefits You Can Get From HMOBlue Option Or With Your Medicaid Card

For some services, you can choose where to get the care. You can get these by using your HMOBlue Option membership card. You can also go to providers who will take your Medicaid Benefit card. *You do not need a referral from your PCP to get these services.* Call Member Services at 1-800-650-4359 if you have questions.

Family Planning

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

You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

HIV and STI Screening

You can get this service any time from your PCP or HMOBlue Option doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services. You do not need a referral when you get this service as part of a family planning visit.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).

TB Diagnosis and Treatment

You can choose to go either to your PCP or to the county public health agency for diagnosis and/or treatment. You do not need a referral to go to the county public health agency.

Benefits Using Your Medicaid Card Only

There are some services HMOBlue Option does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency and non-emergency medical transportation will be covered by regular Medicaid. To get non-emergency transportation, you or your provider must call Medical Answering Service (MAS) at the numbers listed below. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing.

Non-emergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

Broome County.....1-855-852-3294

Herkimer County 1-866-753-4524

Oneida County 1-855-852-3288

Otsego County 1-866-333-1030

If you have an emergency and need an ambulance, you must call 911.

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services Not Covered

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

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

You may have to pay for any services that your PCP does not approve. Or, if before you get a service, you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of HMOBlue Option.

If You Get a Bill

If you get a bill for a treatment or services you do not think you should pay for, do not ignore it. Call Member Services at 1-800-650-4359 right away. HMOBlue Option can help you understand why you may have gotten a bill. If you are not responsible for payment, HMOBlue Option will contact the provider and help fix the problem for you.

You have the right to ask for fair hearing if you think you are being asked to pay for something Medicaid or HMOBlue Option should cover. See the Fair Hearing section later in this handbook.

If you have any questions, call Member Services at 1-800-650-4359.

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at 1-800-650-4359 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

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

Service Authorization

Prior Authorization:

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

- Select ambulatory surgery procedures
- Elective, Medically necessary cosmetic surgery
- Select Ancillary Services- i.e. Prosthetics, Orthopedic Devices and DME
- Home Health Care including Home Infusion Nursing and Therapy
- Inpatient Admissions

- Observation Level of Care
- Out-of-Network Services
- Select Surgical Procedures
- Radiological imaging included but not limited to MRA, MRI, CT and PRT Scans
- Diagnosis and Treatment of Sleep Disorders
- New Technology and Treatments
- Radiation Oncology Treatment
- Cardiac Device Implantation
- Some Drugs

Asking for an approval of a treatment or service is called a ***service authorization request.*** To get approval for these treatments or services you need to:

To get approval for these treatments or services you or your doctor may call our Member Services at 1-800-650-4359.

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the care. This is called **concurrent review.**

What happens after we get your service authorization request:

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

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, we used to make the decisions about medical necessity.

After we get your request we will review it under a **standard** or **fast track** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
- Your provider says the review must be faster;
- You are asking for more of a service you are getting right now.

In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision. (See also the Plan Appeals and Fair Hearing sections later in this handbook.)

Timeframes for prior authorization requests:

- **Standard review:** We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- **Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

Timeframes for concurrent review requests:

- **Standard review**: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- **Fast track review**: We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision within 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling Member Services at 1-800-650-4359 or writing to:

Advocacy Department
P.O. Box 4717
Syracuse, NY 13221

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

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal section later in this handbook

Other Decisions About Your Care:

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

Timeframes for other decisions about your care:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- We must tell you at least 10 days before we make any decision about long term services and supports, such as home health care, personal care, CDPAS, adult day health care, and nursing home care.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. **You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.**

You Can Help With Plan Policies

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-800-650-4359 to find out how you can help.

Information From Member Services

Here is information you can get by calling Member Services at 1-800-650-4359.

- A list of names, addresses, and titles of Excellus BlueCross BlueShield's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about HMOBlue Option.
- How we keep your medical records and member information private.

- In writing, we will tell you how HMOBlue Option checks on the quality of care to our members.
- We will tell you which hospitals our health providers work with.
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by HMOBlue Option.
- If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of HMOBlue Option.
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

Keep Us Informed

Call Member Services at 1-800-650-4359 whenever these changes happen in your life:

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

If you no longer get Medicaid, check with your local Department of Social Services. You may be able to enroll in another program.

Disenrollment Options

1. If YOU Want to Leave HMOBlue Option

You can try us out for 90 days. You may leave HMOBlue Option and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in HMOBlue Option for 9 more months, *unless* you have a good reason (good cause).

Some examples of good cause include:

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

- We have not been able to provide services to you as we are required to under our contract with the State.

To change plans:

- Call the Managed Care staff at your local Department of Social Services.
- Call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

You may be able to transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

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

You can ask for a faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.

2. You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave HMOBlue Option if you or the child:
    - move out of your County or service area,
    - changes to another managed care plan,
    - join an HMO or other insurance plan through work,
    - go to prison,
    - otherwise lose eligibility:
    - Your child may have to leave HMOBlue Option or *change plans if he or she:
    - joins a Physically Handicapped Children's Program, or
    - is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services, or
    - * is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan

If you have to leave HMOBlue Option or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at 1-800-505-5678 right away if this happens.

3. We Can Ask You to Leave HMOBlue Option

- You can also lose your HMOBlue Option membership, if you often:
    - refuse to work with your PCP in regard to your care,
    - don't keep appointments,
    - go to the emergency room for non-emergency care,
    - don't follow HMOBlue Option rules,
    - do not fill out forms honestly or do not give true information (commit fraud),
    - cause abuse or harm to plan members, providers or staff, or
    - act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

Plan Appeals

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

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

Your provider can ask for reconsideration:

If we made a decision that your service authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file a Plan Appeal:

If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a **Plan Appeal**.

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at 1-800-650-4359 if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

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

If your Plan Appeal results in another denial you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.

- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-800-650-4359.

Give us your information and materials by phone, fax, mail, or in person:

Phone..... 1-800-614-6575 or TTY/TDD 1-800-662-1220

Fax.....315-671-6656

Mail .....P.O. Box 4717, Syracuse, NY 13221

In Person ..... 333 Butternut Drive, Syracuse, NY 13214

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for out-of-network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1) a statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider. Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.
  2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider.
- lf you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your appeal:
  1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
  2) that recommends an out-of-network provider with the correct training and experience who is able to provide the service.

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call HMOBlue Option at 1-800-650-4359 if you are not sure what information to give us.
- Plan 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.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong:**
  - you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.
  - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - you may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals**: If we have all the information we need we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast track Plan Appeals**: If we have all the information we need, fast track Plan Appeal decisions will be made in 2 working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
- We will tell you within 72 hours if we need more information.
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
- We will tell you our decision by phone and send a written notice later.

Your Plan Appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your **Plan 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 **Plan 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; or
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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

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

You or your representative 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 1-800-650-4359 or writing.

You or your representative can file a complaint with the plan if you don't agree with our decision to take more time to review your Plan 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 you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

- not medically necessary;
- experimental or investigational;
- not different from care you can get in the plan's network; or
- available from a participating provider who has correct training and experience to meet your needs.

The original denial will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. **You must ask for your Plan Appeal:**

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

If your Plan Appeal results in another denial you may ask for a Fair Hearing. See the Fair Hearing section later in this handbook. If you lose your Plan appeal and Fair Hearing, you may have to pay for the cost of any continued benefits that you received.

External Appeals

You have other appeal rights if we said the service you are asking for was:

1) not medically necessary;
2) experimental or investigational;
3) not different from care you can get in the plan's network; or
4) available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination; **or**
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited External Appeal is necessary; **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have **4 months** after you receive the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-800-650-4359 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at 1-800-650-4359.

Your External Appeal will be decided in 30 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: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast track Plan Appeal within 24 hours, AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track **Plan Appeal** in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal 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.

If you ask for a **Plan Appeal**, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Fair Hearings

You may ask for a Fair Hearing from New York State if.

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about your staying or leaving HMOBlue Option.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with HMOBlue Option. If HMOBlue Option agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted;
  - deny payment for care you received; or
  - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

  You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.

However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone – call toll-free 1-800-342-3334
2. By fax – 518-473-6735
3. By internet – www.otda.state.ny.us/oah/forms.asp
4. By mail – NYS Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   Managed Care Hearing Unit
   P.O. Box 22023
   Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision HMOBlue Option made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-650-4359 to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint Process

Complaints:

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

You can call Member Services at 1-800-650-4359 if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

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:

New York State Department of Health
Bureau of Consumer Services
Complaint Unit
OHIP DHPCO 1CP-1609
Albany, New York 12237

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

How to File a Complaint with Our Plan

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call Member Services at 1-800-650-4359 Monday – Friday from 8:00 am to 6:00 pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call Member Services at 1-800-650-4359 and request a complaint form. It should be mailed to:

Excellus Health Plan, Inc.
P.O. Box 21146
Eagan, MN 55121

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 work days. The letter will tell you:

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

You can also provide information to be used reviewing your complaint in person or in writing. Call HMOBlue Option at 1-800-650-4359 if you are not sure what information to give us.

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 can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 work days after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you;
- The complaint appeal must be made in writing. If you make a complaint appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal we will send you a letter within 15 work 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 work days. If a delay would risk your health you will get our decision in 2 work 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.

Your Rights:

As a member of HMOBlue Option, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from HMOBlue Option including hours open, benefits, and member rights and duties.
- Be told by your PCP what is wrong and what can help in the language you know without worry about benefit coverage.
- Get a second opinion about your care.
- Be a part of your treatment or plan of care from your provider and make decisions about your care.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected.
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval.
- Use the health plan complaint system to file any complaints or appeals. You can complain to the New York State Department of Health or the local Department of Social Services (if a Medicaid member) any time you feel you were not fairly treated.
- Use the State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

Your responsibilities:

As a member of HMOBlue Option, you agree to:

- Work with your PCP on your health, ask questions, and agree on the plan of care.
- Give your health plan and PCP changes in your health, how you are feeling now, home address, and telephone number.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.
- Suggest changes to the health plan for member rights and duties.

Advance Directives

There may come a time **when you can't decide about your own health care**. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, **you can appoint an adult you trust to make decisions for you**. Be sure to talk with your PCP, your family or others close to you so they will know what you want. Third, it is best if you **put your thoughts in writing**. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

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

CPR and DNR - You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

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

Important Phone Numbers and Information

Your PCP:..... _____

HMOBlue Option

Member Services Department..... 1-800-650-4359

TTY 1-800-662-1220

New York State Medicaid Helpline 1-800-541-2831

AfterHours

For medical care on weekends and evenings call your PCP for help getting an appointment.
The phone number is listed on your ID card.

24 Hour Toll-Free Number 1-800-650-4359

Your nearest Emergency Room: ....._____

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

NYS Office of Mental Health (OMH): Customer Relations 1-800-597-8481

NYS Office of Alcoholism and Substance Abuse Services (OASAS)
Consumer Complaint Line.....1-518-457-2020

To submit a written Internal Appeal, send to:

Customer Advocacy Unit PO Box 4717 Syracuse, NY 13221

Local Department of Social Services Addresses and Phone Numbers

Broome County DSS:
36-42 Main Street, Binghamton, NY 13905-3199.....1-607-778-8850

Herkimer County DSS:
301 North Washington Street, Suite 2110, Herkimer, NY 13350 1-315-867-1291

Oneida County DSS:
800 Park Avenue, Utica, NY 13501-2981 1-315-798-5700

Otsego County DSS:
County Office Building, 197 Main Street, Cooperstown, NY 13326-1196 1-607-547-1700

New York Medicaid Choice 1-800-505-5678

NYS HIV/AIDS Hotline.....1-800-541-AIDS (2437)
Spanish.....1-800-233-SIDA (7432)
TDD 1-800-369-AIDS (2437)

HIV Uninsured Care Programs.....1-800-542-AIDS (2437)
TDD 1-518-459-0121

Partner Assistance Program 1-800-541-AIDS (2437)

Child Health Plus 1-855-693-6765
Free or low cost health insurance for children

NYS Growing Up Healthy Hotline 1-800-522-5006

Social Security Administration 1-800-772-1213

NYS Domestic Violence Hotline 1-800-942-6906
Spanish 1-800-942-6908
Hearing Impaired 1-800-810-7444

Americans with Disabilities Act (ADA) Information Line 1-800-514-0301
TDD 1-800-514-0383

Medical Answering Services (MAS)
Broome County 1-855-852-3294
Herkimer County 1-866-753-4524
Oneida County 1-855-852-3288
Otsego County 1-866-333-1030

Healthplex (Dental Services) 1-800-468-9868

Pharmacy Help Desk 1-800-650-4359

Local Pharmacy: ..... _____

Other Providers:

_____ _____

_____ _____

_____ _____

Patient Self Determination Policy

Advance Directives

Do Not Resuscitate Orders
Health-Care Proxies (Proxy enclosed)
Living Wills

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Pursuant to the Federal Patient Self-Determination Act of 1990 and the New York State Health Department Regulations, we must provide our members with certain information regarding their rights under New York Law to:

(1) make medical care decisions,

(2) accept or refuse medical treatment; including the right to refuse life-sustaining medical and surgical treatment, and

(3) make advance directives about their medical care in the event they lack capacity to make such decisions.

This policy is one of the documents we must distribute to members upon enrollment.

1. **Informed Consent.**

Any competent adult (which includes a person who is under 18 years of age and who is either married or has a child) has the right to accept, decline, terminate or withdraw medical treatment, even life-saving and life-sustaining treatment, and can refuse nutrition and hydration. In addition, pregnant minors have the right to consent to treatment relating to their pregnancy and a parent's consent is not required when emergency treatment involves a minor.

A member is entitled to be advised of an existing medical condition, the prognosis of the medical condition, the possible treatments which are professionally sound for the medical condition, and the probable benefits and risks associated with each treatment before the member makes a decision regarding medical care. This is known as the "informed consent" rule.

A member cannot require us or our physicians or other health-care providers to provide treatment which is not professionally sound or would be medically futile for the medical condition in question.

2. **Advance Directives.**

New York Law allows the following types of advance directives:

1. Consents to Orders Not to Resuscitate, commonly known as "Do Not Resuscitate Orders" ("DNR Orders")
2. Health-Care Proxies
3. Living Wills

The law and our policy on these advance directives is described below.

3. **Consents to DNR Orders.**

A DNR Order is an order issued by the member's attending physician which permits the health-care provider not to administer cardiopulmonary resuscitation (CPR), in the event of a cardiac or respiratory arrest. CPR is a medical procedure administered to restore cardiac function or to support ventilation in the event of cardiac or respiratory arrest.

If a member does not consent to the issuance of a DNR Order, it will be presumed that the member has consented to CPR in the event of cardiac or respiratory arrest.

A member can give consent to the issuance of a DNR Order either orally or in writing. If the consent is oral, it can only be made in a hospital (not in an HMO facility and not in a physician's office). An oral consent must be clearly stated before two witnesses who are at least 18 years of age, one of whom must be a physician affiliated with the hospital. The substance of the oral consent must be entered in the member's hospital medical record.

Written consent to the issuance of a DNR Order can be made in any form and must be witnessed by two persons who are at least 18 years of age, and who must also sign the consent. Written consent can be made in any HMO facility or physician's office.

A member who gives written consent to the issuance of a DNR Order should supply the HMO physician with a copy of the consent so that it can be entered in the member's medical records. However, a written consent is only effective when the member is a patient in a hospital or residential care facility. It is not effective while a member is being treated in an HMO facility or physician's office.

The consent will be followed by the HMO and its physicians only if the member is hospitalized and lacks capacity to make medical decisions, which will be determined by the member's attending physician.

A member's written or oral consent to the issuance of a DNR Order can be terminated at any time. The termination can be in writing (which does not have to be witnessed), or by oral declaration to an HMO employee or to a physician (the termination should be noted in the primary care physician's medical record). No special language is needed, so long as the member expresses an intent to terminate consent. Termination can even be accomplished by a body message, such as a nod of the head, if the member cannot talk or write.

If a member has not consented to a DNR Order, such consent can be made by the member's surrogate, provided the member lacks capacity to make medical-care decisions, but only in certain limited situations which are discussed below.

The Surrogate is the first of the following persons who exists, and is able and willing to make a decision:

- the court-appointed committee of the member,
- the member's spouse,
- a member's son or daughter who is 18 years of age or older,
- a member's parent,
- a member's brother or sister who is 18 years of age or older,
- a close friend of the member.

A Surrogate can only consent to the issuance of a DNR Order if the member's attending physician, after a personal examination of the member, determines (with a reasonable degree of medical certainty) that:

- the member has a terminal condition; or
- the member is permanently unconscious; or
- resuscitation would be medically futile; or
- resuscitation would impose an extraordinary burden on the member in light of the member's medical condition and the expected outcome of resuscitation.

The attending physician's determination must be supported by a second opinion.

4. **Health-Care Proxies.**

Under New York State law, any competent member has the power to appoint another adult (and an alternate adult) to act as their health-care agent. The appointment is made by executing a health-care proxy. A health-care proxy must be in writing, signed and dated by the member before two witnesses, who must also sign the proxy.

Any adult person can be appointed as a health-care agent, except: a non-relative employee of a hospital and any non-relative employee of the HMO. It is suggested that members refrain from appointing HMO physicians as health-care agents, since the physician will not be able to subsequently act as the member's physician.

The health-care proxy form published by the New York State Department of Health should be utilized for all health-care proxies, since this form will be generally accepted by all hospitals, residential health-care facilities and other health-care providers, and will be familiar to the HMO's physicians and staff. This form is included in the New York State Department of Health's publication entitled "Appointing Your Health-Care Agent - New York State's Proxy Law."

The HMO or the primary care physician will supply the New York State Department of Health's health-care proxy when requested.

The health-care proxy can specify a date, event or condition when it shall terminate, can state the member's wishes or instructions about health-care decisions and can contain conditions and limitations on the health-care agent's power to make medical-care decisions. For example, a member can:

- limit the duration of the health-care proxy.
- limit its use to only certain conditions, such as an impending surgery and recovery.
- specify that CPR is not to be administered.
- prohibit or insist on certain medical or surgical procedures.

While the member has capacity, the member has full and complete power to make their own health-care decisions, and the health-care proxy document is ineffective. If the member lacks capacity, as determined by the member's attending physician, the agent has full and complete power to make medical-care decisions for the member unless limitations are included in the health-care proxy. The agent has the right to receive all medical information pertaining to the member and be given medical advice with respect to the member to the same extent the member would have a right to receive such information or advice.

In the event that a medical-care decision is made by the agent to withdraw or withhold life sustaining treatment, the attending physician must obtain a second medical opinion to confirm the initial opinion of the member's lack of capacity.

Each member who signs a health-care proxy is urged to make their decision and wishes with respect to future medical care known to the agent. Each member should discuss these matters with the agent.

If the member's wishes are not known, the health-care decisions can be made by the agent in accordance with the member's best interests. The member's religious and moral beliefs may be considered. Agents cannot make decisions regarding the administration of artificial nutrition and hydration, unless the member's wishes are known or can be reasonably ascertained.

The health-care proxy can be revoked by the member at any time. Revocation can be either oral or written and should be immediately entered in the member's medical records as soon as the revocation becomes known to the HMO or physician.

Our physicians and providers will honor any health-care decision properly made by an agent pursuant to a properly-signed and witnessed health-care proxy, if the attending physician determines that the member lacks capacity to make medical care decisions.

5. **Non-Statutory Advance Directives (i.e., Living Wills).**

DNR orders and health-care proxies are the only advance directives recognized by statute in New York State. However, courts have recognized and upheld the use of other written documents (commonly called "living wills"), if there is "clear and convincing" evidence of a patient's desire to withhold or withdraw certain medical treatments when the patient lacks capacity to make medical-care decisions.

Under the court cases, the living will has to be created and signed by the member while the member has capacity to make medical decisions. The usual living will in New York State is a written statement that "no heroic measures or extraordinary treatment" be provided if the member is incapacitated.

Since New York does not have a living will statute, it is our policy to require a court order finding "clear and convincing" evidence of a patient's desire to withhold or withdraw medical treatments before we will honor instructions made in a living will.

Any member who desires a living will should consult their attorney.

6. **Member's Free Choice Whether to Utilize an Advance Directive.**

We do not encourage or discourage members to make any type of advance directive.

Our physicians and all staff are reminded that a member cannot be required to make an advance directive.

We will not discriminate against any member in the providing of medical care based on whatever a member has executed as an advance directive.

Each physician or other provider is encouraged to answer any questions regarding a member's rights to make medical-care decisions and to make advance directives.

7. **Documents to Be Distributed Upon Enrollment.**

We will provide copies of this policy as well as the New York State Health Department documents entitled: "Planning in Advance for your Medical Treatment," "Do Not Resuscitate Order - A Guide for Patients and Families," and "Appointing Your Health-Care Agent - New York States Proxy Law," to each person upon enrollment. All documents are contained in this booklet.

8. **Medical Record Notations.**

Each physician or other provider who first treats a member after adoption of this policy will inquire whether the member has an advance directive and will note the response in the member's medical record.

All physicians and other employees are required to immediately enter into a member's medical records, any advance directive or any revocation of an advance directive, which comes to their attention.

(NOTE: In an IPA model HMO, the member's medical record is the medical record maintained by the member's primary care physician).

9. Education of Staff and Community.

We will educate our staff and providers concerning our policies and procedures concerning advance directives.

We will provide education to the community on issues concerning advance directives.

PLANNING IN ADVANCE
FOR
YOUR MEDICAL TREATMENT

Your Right to Decide About Treatment

Adults in New York State have the right to accept or refuse medical treatment, including life-sustaining treatment. Our Constitution and state laws protect this right. This means that you have the right to request or consent to treatment, to refuse treatment before it has started, and to have treatment stopped once it has begun.

Planning in Advance

Sometimes because of illness or injury, people are unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed if you become unable to decide for yourself for a short or long time period. If you don't plan ahead, family members or other people close to you may not be allowed to make decisions for you and follow your wishes.

In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns. You have the right to appoint someone by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy are available in this booklet and from your health care provider.

If you have no one you can appoint to decide for you, or do not want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written, and are often referred to as a Living Will.

You should understand that general instructions about refusing treatment, even if written down, may not be effective. Your instructions must clearly cover the treatment decisions that must be made. For example, if you just write down that you do not want "heroic measures," the instructions may not be specific enough. You should say the kind of treatment that you do not want, such as a respirator or chemotherapy, and describe the medical condition when you would refuse the treatment, such as when you are terminally ill or permanently unconscious with no hope of recovering. You can also give instructions orally by discussing your treatment wishes with your doctor, family members or others close to you.

Putting things in writing is safer than simply speaking to people, but neither method is as effective as appointing someone to decide for you. It is often hard for people to know in advance what will happen to them or what their medical needs will be in the future. If you choose someone to make decisions for you, that person can talk to your doctor and make decisions that they believe you would have wanted or that are best for you when needed. If you appoint someone and also leave instructions about treatment in a Living Will, in the space provided on the Health Care Proxy form itself, or in some other manner, the person you select can use these instructions as guidance to make the right decision for you.

Deciding About Cardiopulmonary Resuscitation

Your right to decide about treatment also includes the right to decide about cardiopulmonary resuscitation (CPR). CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops.

Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the medical staff an order not to resuscitate (DNR order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members, or others close to you can decide.

New York State Department of Health 12/91

Deciding about CPR:
Do-Not-Resuscitate Orders (DNR)

What do CPR and DNR order mean?

CPR - cardiopulmonary resuscitation - refers to the medical procedures used to restart a patient's heart and breathing when the patient suffers heart failure. CPR may involve simple efforts such as mount-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and, in extreme cases, open chest heart massage.

A do-not-resuscitate (DNR) order tells medical professionals not to perform CPR. This means that doctors, nurses and emergency medical personnel will not attempt emergency CPR if the patient's breathing or heartbeat stops.

DNR orders may be written for patients in a hospital or nursing home, or for patients at home. Hospital DNR orders tell the medical staff not to revive the patient if cardiac arrest occurs. If the patient is in a nursing home or at home, a DNR order tells the staff and emergency medical personnel not to perform emergency resuscitation and not to transfer the patient to a hospital for CPR.

Why are DNR orders issued?

CPR, when successful, restores heartbeat and breathing and allows patients to resume their previous lifestyle. The success of CPR depends on the patient's overall medical condition. Age alone does not determine whether CPR will be successful, although illnesses and frailties that go along with age often make CPR less successful.

When patients are seriously ill or terminally ill, CPR may not work or may only partially work, leaving the patient brain-damaged or in a worse medical state than before the heart stopped. In these cases, some patients prefer to be cared for without aggressive efforts at resuscitation upon their death.

Can I request a DNR order?

Yes. All adult patients can request a DNR order. If you are sick and unable to tell your doctor that you want a DNR order written, a family member or close friend can decide for you.

Is my right to request or receive other treatment affected by a DNR order?

No. A DNR order is only a decision about CPR and does not relate to any other treatment.

Are DNR orders ethically acceptable?

It is widely recognized by health care professionals, clergy, lawyers and others that DNR orders are medically and ethically appropriate under certain circumstances. For some patients, CPR offers more burdens than benefits, and may be against the patient's wishes.

Is my consent required for a DNR order?

Your doctor must speak to you before entering a DNR order if you are able to decide, unless your doctor believes that discussing CPR with you would cause you severe harm. In an emergency, it is assumed that all patients would consent to CPR. However, if a doctor decides that CPR will not work, it is not provided.

How can I make my wishes about DNR known?

An adult patient may consent to a DNR order orally by informing a physician, or in writing, such as a living will, if two witnesses are present. In addition, the Health Care Proxy Law allows you to appoint someone you trust to make decisions about CPR and other treatments if you become unable to decide for yourself.

Before deciding about CPR, you should speak with your doctor about your overall health and the benefits and burdens CPR would provide for you. A full and early discussion between you and your doctor will assure that your wishes will be known.

If I request a DNR order, must my doctor honor my wishes?

If you don't want CPR and you request a DNR order, your doctor must follow your wishes or:

- transfer your care to another doctor who will follow your wishes; or
- begin a process to settle the dispute if you are in a hospital or nursing home.

If the dispute is not resolved within 72 hours, your doctor must enter the order or transfer you to the care of another doctor.

Appointing Your Health Care Agent
NEW YORK STATE'S PROXY LAW

A new law called the New York health care proxy law allows you to appoint someone you trust -- for example, a family member or close friend -- to decide about treatment if you lose the ability to decide for yourself. You can do this by using a Health Care Proxy form like the one on the back of this booklet, to appoint your "health care agent."

The law gives you the power to make sure that health care professionals follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors and other health care providers must follow your agent's decisions as if they were your own.

You can give the person you select, your health care agent, as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that he or she has to follow.

Why should I choose a health care agent?

If you become too sick to make health care decisions, someone else must decide for you. Health care professionals often look to family members for guidance. But family members are not allowed to decide to stop treatment, even when they believe that is what you would choose or what is best for you under the circumstances. Appointing an agent lets you control your medical treatment by:

- allowing your agent to stop treatment when he or she decides that it is what you would want or what is best for you under the circumstances;
- choosing one family member to decide about treatment because you think that person would make the best decisions or because you want to avoid conflict or confusion about who should decide; and
- choosing someone outside your family to decide about treatment because no one in your family is available or because you prefer that someone other than a family member decide about your health care.

How can I appoint a health care agent?

All competent adults can appoint a health care agent by signing a form called a Health Care Proxy. You don't need a lawyer, just two adult witnesses. You can use the form printed in the center of this booklet, but you don't have to.

When would my health care agent begin to make treatment decisions for me?

Your health care agent would begin to make treatment decisions after doctors decide that you are not able to make health care decisions. As long as you are able to make treatment decisions for yourself, you will have the right to do so.

What decisions can my health care agent make?

Unless you limit your health care agent's authority, your agent will be able to make any treatment decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments and decide that treatments should not be provided, in accord with your wishes and interests.

If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. Artificial nutrition and hydration are used in many circumstances, and are often used to continue the life of patients who are in a permanent coma.

How will my health care agent make decisions?

You can write instructions on the proxy form. Your agent must follow your oral and written instructions, as well as your moral and religious beliefs. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interests.

Who will pay attention to my agent?

All hospitals, doctors and other health care facilities are legally required to honor the decisions by your agent. If a hospital objects to some treatment options (such as removing certain treatment) they must tell you or your agent **IN ADVANCE.**

What if my health care agent is not available when decisions must be made?

You can appoint an alternate agent to decide for you if your health care agent is not available or able to act when decisions must be made. Otherwise, health care providers will make treatment decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What if I change my mind?

It is easy to cancel the proxy, to change the person you have chosen as your health care agent or to change any treatment instructions you have written on your Health Care Proxy form. Just fill out a new form. In addition, you can require that the Health Care Proxy expire on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent and you get divorced or legally separated, the appointment is automatically cancelled.

Can my health care agent be legally liable for decisions made on my behalf?

No. Your health care agent will not be liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care, just because he or she is your agent.

Is a health care proxy the same as a living will?

No. A living will is a document that provides specific instructions about health care treatment. It is generally used to declare wishes to refuse life-sustaining treatment under certain circumstances.

In contrast, the health care proxy allows you to choose someone you trust to make treatment decisions on your behalf. Unlike a living will, a health care proxy does not require that you know in advance all the decisions that may arise. Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made. The health care proxy is just as useful for decisions to receive treatment as it is for decisions to stop treatment. If you complete a Health Care Proxy form, but also have a living will, the living will provides instructions for your health care agent, and will guide his or her decisions.

Where should I keep the proxy form after it is signed?

Give a copy to your agent, your doctor and any other family members or close friends you want. You can also keep a copy in your wallet or purse or with other important papers.

Appointing a Health Care Agent is a serious decision. Make sure you talk about it with your family, close friends and your doctor.

Do it in advance, not just when you are planning to enter the hospital.

Filling out a health care proxy is voluntary. No one can require to you to do so.

The Health Care Proxy Law takes effect January 1991; forms signed before that date are valid.

About the Health Care Proxy

This is an important legal form. Before signing this form, you should understand the following facts:

1. This form gives the person you choose as your agent the authority to make all health care decisions for you, except to the extent you say otherwise in this form. "Health care" means any treatment, service or procedure to diagnose or treat your physical or mental condition.
2. Unless you say otherwise, your agent will be allowed to make all health care decisions for you, including decisions to remove or provide life-sustaining treatment.
3. Unless your agent knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube), he or she will not be allowed to refuse or consent to those measures for you.
4. Your agent will start making decisions for you when doctors decide that you are not able to make health care decisions for yourself.

You may write on this form any information about treatment that you do not desire and/or those treatments that you want to make sure you receive. Your agent must follow your instructions (oral and written) when making decisions for you.

If you want to give your agent written instructions, do so right on the form. For example, you could say:

If I become terminally ill, I do/don't want to receive the following treatments....

If I am in a coma or unconscious, with no hope of recovery, then I do/don't want....

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want....

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list of the treatments about which you may leave instructions.

- artificial respiration
- artificial nutrition and hydration (nourishment and water provided by feeding tube)
- cardiopulmonary resuscitation (CPR)
- antipsychotic medication
- electric shock therapy
- antibiotics
- psychosurgery
- dialysis
- transplantation
- blood transfusions
- abortion
- sterilization

Talk about choosing an agent with your family and/or close friends. You should discuss this form with a doctor or another health care professional, such as a nurse or social worker, before you sign it to make sure that you understand the types of decisions that may be made for you. You may also wish to give your doctor a signed copy. **You do not need a lawyer to fill out this form.**

You can choose any adult (over 18), including a family member, or close friend, to be your agent. If you select a doctor as your agent, he or she may have to choose between acting as your agent or as your attending doctor; a physician cannot do both at the same time.

Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming someone who works for that facility as your agent. You should ask staff at the facility to explain those restrictions.

You should tell the person you choose that he or she will be your health care agent. You should discuss your health care wishes and this form with your agent. Be sure to give him or her a signed copy. Your agent cannot be sued for health care decisions made in good faith.

Even after you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you object. You can cancel the control given to your agent by telling him or her or your health care provider orally or in writing.

Filling Out the Proxy Form

Item (1) Write your name and the name, home address and telephone number of the person you are selecting as your agent.

Item (2) If you have special instructions for your agent, you should write them here. Also, if you wish to limit your agent's authority in any way, you should say so here. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

Item (3) You may write the name, home address and telephone number of an alternate agent.

Item (4) This form will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want the health care proxy to expire.

Item (5) You must date and sign the proxy. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Two witnesses at least 18 years of age must sign your proxy. The person who is appointed agent or alternate agent cannot sign as a witness.

New York State Department of Health 1991

Health Care Proxy

(1) I, _____
(your name)

appoint _____
(name, home address and telephone number of agent)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) Optional instructions: I direct my agent to make health care decisions in accord with my wishes and limitations as stated below, or as he or she otherwise knows. Note that unless your agent knows your wishes about artificial nutrition and hydration (feeding tubes), your agent will not be allowed to make decisions about artificial nutrition and hydration. (Attach additional pages if necessary.)

_____

_____

_____

_____

(3) Name of substitute or fill-in agent if the person I appoint above is unable, unwilling or unavailable to act as my health care agent.

_____
(name, home address and telephone number of substitute)

_____

_____

(4) Unless I revoke it, this proxy shall remain in effect indefinitely, or until the date or conditions stated below. This proxy shall expire (specific date or conditions, if desired):

_____

_____

(5) Signature _____

Address _____

Date _____

Statement by Witnesses (must be 18 or older)

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Witness 1 _____

Address _____

Witness 2 _____

Address _____

Excellus

A nonprofit independent licensee of the BlueCross BlueShield Association

Important Facts Regarding Your Authorization to Share Protected Health Information

- In order to comply with Federal HIPAA regulations health plans must obtain a member's permission to share his/her protected health information with any other person. There are limited exceptions to this.

- As permitted by law, we will continue to communicate to providers of care involved in your treatment: (1) our payment activities in connection with your claims, (2) your enrollment in our health plan and (3) your eligibility for benefits.

- Until a child reaches age 18, parents may access most of their child's health information without first obtaining the child's permission. However, regardless of the child's age, parents do not have access to diagnosis or treatment information for sexually transmitted diseases, abortion, and drug or alcohol abuse unless the child specifically authorizes the release of such information.

- This form is used to authorize us to share your protected health information. Each person you identify will have the same access to your information. If you would like each person to access *different* information or to have access to your information for a *different* period of time, you'll need to complete separate forms for each individual or time period.

- We will NOT disclose information relating to genetic testing, substance use disorder, mental health, abortion, and sexually transmitted disease information unless you initial the corresponding condition in Part D. If you would like to authorize us to release information regarding HIV/AIDS, New York State requires that a different form be completed. To obtain a copy of this form, please contact our office at the telephone number listed on your identification card, or access the form at the following website: http://www.health.state.ny.us/diseases/aids/forms/informedconsent.htm.

- If you need additional forms, you may copy this form, contact our office at the telephone number listed on your identification card or visit our Web site at https://www.excellusbcbs.com and search for "Manage Your Privacy".

- Please ensure you have fully completed the form so that we may honor your request.

RETAIN A COPY FOR YOUR RECORDS

AUTHORIZATION TO EXCELLUS HEALTH PLAN, INC. ("HEALTH PLAN") TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

☐ **Check here only if you are authorizing access to psychotherapy notes. If checked, this form cannot be used for any other purpose. You must complete a separate form for authorizing access to any other information. If this box is checked, skip Part D.**

PLEASE PRINT

PART A: MEMBER/INDIVIDUAL WHO IS THE SUBJECT OF THE INFORMATION TO BE DISCLOSED				
LAST NAME	FIRST NAME	MI	DATE OF BIRTH	IDENTIFICATION # - located on ID card(s)
CURRENT ADDRESS		CITY		STATE/ZIP CODE

PART B: HEALTH PLAN CAN SHARE MY INFORMATION WITH THE FOLLOWING PERSON(S)	
NAME OF PERSON/ORGANIZATION	ADDRESS
NAME OF PERSON/ORGANIZATION	ADDRESS

PART C: REASON FOR MEMBER/INDIVIDUAL (PART A) AUTHORIZING DISCLOSURE

☐ At my request ☐ Other: _____

PART D: HEALTH PLAN CAN SHARE THE FOLLOWING INFORMATION *(select D-1 **or** D-2 and if applicable, D-3)*
NOTE: Skip this section if psychotherapy was checked at the top of this form

D-1. ☐ I would like you to disclose any information requested by the person or entity named in Part B. This includes information in Part D-3 (below) only if I placed my initials next to the condition. If my initials do not appear in D-3, information related to those conditions will not be disclosed.

- OR –

D-2. I would like to limit the disclosure of information to a specific type of information, provider, condition or date(s). If this area is blank I do not wish to limit the disclosure of my information.

☐ Enrollment *(e.g. eligibility, address, dependents, birth date)*
☐ Benefit *(e.g. benefit coverage, usage, limits)*
☐ Claim *(e.g. status, provider, dates, payment, diagnosis)*
☐ Clinical records *(e.g. doctor/facility, case management)*
☐ Other limitation: _____
☐ Date Range _____ to _____

- AND, IF APPLICABLE -

D-3. Unless specifically indicated below, information will not be disclosed related to the following conditions. If I have placed my initials next to one or more of these conditions, the Health Plan is authorized to disclose information related to those conditions.

____ Genetic testing
____ Sexually transmitted diseases
____ Substance use disorder
____ Abortion
____ Mental health *(excluding psychotherapy notes)*

Note: A separate form must be completed in order to authorize release of information related to HIV/AIDS. The NYS approved form can be found at http://www.health.ny.gov/diseases/aids/providers/forms/informedconsent.htm

CONTINUED ON THE NEXT PAGE

PART E: ACKNOWLEDGEMENT (PLEASE READ AND SIGN)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- Unless you receive revocation in writing, this authorization will be valid until the date specified here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ **Date:** _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative Signature _____

Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐ Other * _____

** You must provide documentation supporting your legal authority to act on behalf of the member*

RETURN TO:

Excellus Health Plan
P.O. Box 21146
Eagan, MN 55121

or Fax: 315-671-7079

Please keep a copy for your records

THE NEW YORK CONSUMER GUIDE TO HEALTH INSURERS

The New York Consumer Guide to Health Insurers
evaluates the performance of HMOs and other insurers.

TO OBTAIN YOUR FREE COPY, WRITE TO:

New York State Department of Financial Services
Publications Unit
Agency Building One, 5th Floor
Albany, New York 12257

Or e-mail your request to:
Publicat@dfs.ny.gov

Guides are also available through the
New York State Department of Financial Service's Website:
www.dfs.ny.gov

Please send a copy of the current *New York Consumer Guide to Health Insurers* to:

NAME: _____

ADDRESS: _____

CITY/STATE: _____

ZIP CODE: _____

NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan's final adverse determination for health services if you are the patient or the patient's designee, or within 60 days if you are a provider appealing on your own behalf to DFS.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210 or Fax to: (800) 332-2729. For help, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov.

1. Applicant Name:			
2. Patient Name:			
3. Patient Address:	Street:		
	City:	State:	Zip Code:
4. Patient Phone Number:	Primary: ( )	Secondary: ( )	
5. Patient Email Address:			
6. Patient Health Plan:		ID #:	
7. Patient's Physician/Prescriber:			
8. Physician/Prescriber Address:	Street:		
	City:	State:	Zip Code:
9. Physician/Prescriber Phone #:	( )	Fax:	( )
10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?	☐ Yes	☐ No	☐ Don't know
11. To be completed if the applicant is the patient's designee			
Complete this section only if a designee is submitting this appeal on a patient's behalf. If the patient's provider is the designee complete section 14 instead of this section.			
Name of Designee:			
Relationship to Patient:			
Address:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Designee Email Address:			

12. **Reason for Health Plan Denial** - check only one and **attach** a completed physician's attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:

	☐ Not medically necessary	☐ Experimental/investigational for a clinical trial
	☐ Experimental/ investigational	☐ Experimental/investigational for a rare disease
	☐ Out-of-network and the health plan proposed an alternate in-network service	☐ Out-of-network referral
	☐ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)	

13. This appeal may be expedited. Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.		
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.	
	☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health, and patient's physician will complete the Physician Attestation and send it to the Department of Financial Services.	
	☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient's prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.	
If Standard check one:	☐ Standard Formulary Exception (72 hours)	☐ Standard Appeal for all other appeals (30 days)

***** If expedited you must call 888-990-3991 when the application is faxed*****

14. To be completed if applicant is patient's provider

Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient's designee. The initial denial and final adverse determination from the first level of appeal must be attached.

☐ Provider filing own behalf	☐ Provider filing as designee on behalf of patient		
Provider Name:			
Person or Firm Representing Provider (if applicable):			
Contact Person for Correspondence:			
Address for Correspondence:	Street:		
	City:	State:	Zip Code:
Phone Number:	( )	Fax:	( )
Email Address:			

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient's designee, I agree to pay the external appeal agent's fee in full if the health plan's concurrent denial is upheld, or to pay half of the agent's fee if the health plan's concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

Provider Signature:	

15. Description and date(s) of Service: (Attach any additional information you want considered):

16. External Appeal Eligibility (Check one):	
	☐ Attached is final adverse determination from the health plan.
	☐ Attached is the health plan's letter waiving an internal appeal.
	☐ Patient requests expedited internal appeal at same time as the external appeal.
	☐ Health plan did not comply with internal appeal requirements for patient appeal.

17. External Appeal Fee	
You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.	
Please check one:	☐ Enclosed is a check or money order made out to the health plan.
	☐ Application was faxed and fee will be mailed to the Department within 3 days.
	☐ Patient is covered under Medicaid or Child Health Plus.
	☐ Patient requests fee waiver for hardship and will provide documentation to the health plan.
	☐ Health plan does not charge a fee for an external appeal or fee is not required.

PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL

The patient, the patient's designee, and the patient's provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient's health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent's decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient's designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

Signature:			
Print Name:			
Relationship to patient, if applicable:			
Patient Name:		Age:	
Patient's Health Plan ID#:			
Date: (required)			

PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient's physician must complete this attestation for any external appeal of a health plan's denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The patient's prescriber may also request an expedited formulary exception appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient's medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany NY, 12210
or Fax to: (800) 332-2729.

Type of Review Requested:	☐ Standard Appeal (30 days), or for a non-formulary drug (72 hours)	☐ Expedited Appeal (72 hours), or for a non-formulary drug (24 hours)
If Expedited check one:	☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized. ☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient's life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient's health. ☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.	
If Expedited complete both:	☐ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours (or 24 hours for a non-formulary drug) of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.	
	During non-business days, I can be reached at: ( )	

- For an **expedited appeal**, the patient's physician, or for a non-formulary drug, the patient's prescribing physician or other prescriber, must complete the box below and item **14**. **You must send information to the agent immediately in order for it to be considered.**
- For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient's physician must complete items **1-10 and 14**.
- For a **clinical trial** denial, the patient's physician must complete items **1-9, 11 and 14**.
- For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient's physician must complete items **1-10 and 14**.
- For an **out-of-network referral** denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient's physician must complete items **1 - 9, 13 and 14**.
- For a **rare disease** denial, a physician, other than the treating physician, must complete items **1-9, 12 and 14**.

1. Name of Physician (or Prescriber) completing this form:	
To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient's treating physician.	

2. Physician (or Prescriber) Address:	Street:		
	City:	State:	Zip Code:
3. Contact Person:			
4. Phone Number:	( )	Fax:	( )
5. Physician (or Prescriber) Email:			
6. Name of Patient:			
7. Patient Address:			
8. Patient Phone Number:			
9. Patient Health Plan Name and ID Number:			

10. Experimental/Investigational Denial or Out-of-Network Service Denial
(Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

a. For an Experimental/Investigational Denial:

As the patient's physician I attest that (select one without altering):

OR	☐ Standard health services or procedures have been ineffective or would be medically inappropriate.
	☐ There does not exist a more beneficial standard health service or procedure covered by the health plan.
AND	☐ I recommended a health service or pharmaceutical product that, based on the following **two** documents of medical and scientific evidence **outlined in c and d below**, is likely to be more beneficial to the patient than any covered standard health service.

b. For an Out-of-Network Service Denial

☐ As the patient's physician I attest that the following out-of-network health service (identify service):

is materially different from the alternate in-network health service recommended by the health plan and (based on the following **two** documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

c. List the documents relied upon and attach a copy of the documents:

Document #1 Title:					
Publication Name:		Issue Number:		Date:	
Document #2 Title:					
Publication Name		Issue Number:		Date:	

d. Supporting Documents		
The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)		Check the applicable documents:
☐	Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;	☐ Document #1 ☐ Document #2
☐	Peer-reviewed abstracts accepted for presentation at major medical association meetings;	☐ Document #1 ☐ Document #2
☐	Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;	☐ Document #1 ☐ Document #2
☐	The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network's Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard's Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;	☐ Document #1 ☐ Document #2
☐	Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.	☐ Document #1 ☐ Document #2

11. Clinical Trial Denial	
☐	There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.

Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.

12. Rare Disease Treatment Denial If provision of the service requires approval of an Institutional Review Board, include or attach the approval.	
☐	As a physician, other than the patient's treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient's rare disease, and such benefit outweighs the risk of the service.
☐ I do ☐ I do not have a material financial or professional relationship with the provider of the service (check one).	
Check one:	☐ The patient's rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
	☐ The patient's rare disease affects fewer than 200,000 U.S. residents per year.

13. Out-of-Network Referral Denial	
As the patient's attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.	
Name of out-of-network provider:	
Address of out-of-network provider:	
Training and experience of out-of-network provider: (e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).	

14. Physician (or Prescriber) Signature			
I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.			
Signature of Physician (or Prescriber):		Date:	
Physician (or Prescriber) Name: (Print Clearly):			

HELPFUL HINTS FOR COMPLETING THE EXTERNAL APPEAL APPLICATION

Some sections of the application can be confusing. This will help explain what is expected for those sections.

Application

- Number 11 is only required if the patient has designated someone other than the provider to act on their behalf.
- Number 12 indicates the reason the health plan denied the service. This information is found on the Final Adverse Determination (denial letter) from the health plan.
- The Type of Review must be completed in number 13 if an expedited appeal is being requested. External Appeals can only be expedited if the denial falls into one of these categories. If you already received the services your appeal cannot be expedited. You must also indicate if this is for a Standard Formulary Exception or a Standard External Appeal.
- Number 14 is required if the provider is submitting the application on their own behalf or behalf of the patient.
- Number 15 is to be used to describe the services requested. You can attach a separate document with this information.
- Number 17 relates to the fee that a health plan may charge for the external appeal. The final adverse determination will indicate if the health plan charges a fee.
- Patient Consent to the Release of Records for NYS External Appeal – this document must be signed by the patient or their authorized representative. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased the document must be signed by the patient's healthcare proxy or executor. If signed by a guardian, healthcare proxy or executor, a copy of the legal supporting document should be included.

Physician's Attestation

- For medical necessity, experimental/investigational, and out-of-network appeals, the first section is required if the attending physician is requesting an expedited appeal because the standard 30-day timeframe would jeopardize the patient's life, health or ability to regain maximum function, or the delay would pose an imminent or serious threat to the patient's health. The attending physician must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination within 72 hours of receipt. The decision must be issued even in the event of incomplete medical information or unanswered questions due to the inability to reach the attending physician.
- For formulary exception appeals, the first section is required if the attending physician or prescriber is requesting an expedited appeal because the patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug. The attending physician or prescriber must also include a phone number where they can be reached during non-business hours. This is important since the External Appeal Agent must make a determination with 24 hours of receipt. The decision must be issued even in the event of

incomplete medical information or unanswered questions due to the inability to reach the attending physician/prescriber.

- Number 10 is required for Experimental/Investigational and Out-of-Network Service denials (where the health plan offers an alternate in-network service that is not materially different from the out-of-network service). Subsections a, c and d are required when appealing an experimental/investigational denial.
    - Subsections b, c and d are required for Out-of-Network Service denials.
    - Subsection c. must include information on the medical and scientific evidence (clinical peer reviewed literature) that supports the service requested for the patient's condition. Two articles are required. This section MUST be completed in full, "See attached" will not suffice. The documents that are acceptable for submission are described in subsection d. There is no requirement that the two documents be from different categories.
- Number 11 is required for coverage in a clinical trial. Please note, the Affordable Care Act requires coverage of routine patient costs associated with approved clinical trials. This requirement does NOT apply to grandfathered health plans.
- Number 12 is required for the Experimental/Investigational denials for treatment of a rare disease. The physician signing the attestation for treatment of a rare disease cannot be the patient's attending physician. They must disclose any relationship with the patient's attending physician and indicate which definition of "rare disease" applies to the patient's condition.
- Number 13 must be completed for out-of-network referral denials (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient). The name and address of the out-of-network provider must be included as well as their training and experience. The information provided will be used by the clinical peer reviewer when comparing the qualifications of the in-network provider(s) to the out-of-network provider. Information such as the out-of-network provider's curriculum vitae, Board certification, number of years of experience treating the condition, the number of times the out-of-network provider has performed the requested procedure and the outcomes of those procedures, and any other relevant information should be provided. This information may be provided in an attachment to the application.
- Number 14 must be signed by a Physician. Physician is defined in NYS Education law as an MD or DO. Attestations signed by any other provider will not be accepted. For formulary exception appeals, #14 may be signed by a physician or prescriber.

165 Court Street
Rochester, New York 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

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.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

This notice takes effect April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

We understand that medical information about you and your health is personal. We are committed to safeguarding your protected health information (PHI).

PHI is any information that can identify you as an individual and your past, present or future physical or mental health condition.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. The law requires us to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the notice that is currently in effect.

OUR LEGAL DUTY

We **(Excellus BlueCross BlueShield)** are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning PHI. We must follow the privacy practices that are described in this notice while it is in effect, including notification should there be a breach of your unsecured PHI.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the contact information at the end of this notice.

Uses and Disclosures of Nonpublic Personal Information

Nonpublic Personal Information is information you give us on your enrollment form, claim forms, premium payments etc. For example: names, member identification number, social security number, addresses, type of health care benefits, payment amounts, etc.

We will not give out your nonpublic personal information to anyone unless we are permitted to do so by law or have received a signed authorization form from the member. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. You may revoke this authorization in writing by completing an authorization cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization before your authorization cancellation form was processed.

Treatment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law. We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

To You: We must disclose your PHI to you, as described in the Individual Rights section of this notice, below. We may also use and disclose PHI to tell you about recommended possible treatment options or alternatives or to tell you about health related benefits or services that may be of interest to you.

To Family and Friends: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency situation, we will only disclose the minimum amount necessary.

To Our Business Associates: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors in order for the funeral directors to carry out their duties.

Organ Donation: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine whether we are in compliance with federal privacy laws.

Process and Proceedings: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Marketing and Fundraising: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

Genetic Nondiscrimination Act (GINA): **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

Breach of Unsecured Information: **We will notify you should there be a breach of unsecured information.** We are required to notify you if there is any acquisition, access, use, or disclosure of your unsecured PHI that compromises the security or privacy of your PHI.

Psychotherapy Information: **We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.** Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

Individual Rights

Access: You have the right to inspect and/or copy your PHI, with limited exceptions such as information a licensed health care professional, exercising professional judgment, determines that providing access is reasonably likely to endanger the life, physical safety or cause someone substantial harm. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. If you request copies, we reserve the right to charge you a reasonable fee for each copy, plus postage if the copies are mailed to you.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI. The list will not include disclosures we made for the purpose of treatment, payment, healthcare operations, disclosures made with your authorization, or certain other disclosures. To request a disclosure accounting you may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us. The request may not exceed a six year time period. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your PHI, a description of the PHI we disclosed and the reason for the disclosure. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. As permitted by law, we will not honor these requests, as it prohibits us from administering your benefits.

Confidential Communication: You have the right to request that we communicate with you confidentially about your PHI. We will honor a request to communicate to an alternative location if you believe you would be endangered if we do not communicate to the alternative location. We must accommodate your request if it is reasonable and specifies the alternative location. To request a form to be completed and returned to us, you may contact us using the telephone number on the back of your identification card.

Amendment: You have the right to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or if we determine the information is accurate. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be attached to the information you wanted amended. You may contact us using the telephone number on the back of your identification card to obtain a form to be completed and returned to us.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the contact information at the end of this notice to obtain this notice in written form.

Safeguards

It is our policy to keep all information about you confidential in all settings. It is so important to us that we take the following steps:

- our employees sign an agreement to follow our Code of Business Conduct;
- our employees are required to complete our privacy training program;
- we have implemented the necessary sanctions for violation of our privacy practices;
- we have a privacy oversight committee that reviews our privacy practices;
- we have a security coordinator to detect and prevent security breaches;
- all computer systems that contain personal information have security protections; and
- we randomly check provider offices on a routine basis to ensure that medical records are kept in secure locations.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information at the end of this notice.

If you are concerned that we may have violated your privacy rights, as described above, or you disagree with a decision we made about access to your PHI or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us confidentially communicate with you at an alternative location, you may complain to us using the contact information at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Rights or Questions:

Contact Office: Customer Care

Phone: Please call the telephone number on your identification card.

Privacy Complaints:

Contact Office: Privacy Officer

Address: 333 Butternut Dr.
Dewitt, NY 13214-1803

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

MEMBER ALERT!!!

TO ALL MEMBERS OF MEDICAID MANAGED CARE PLANS

If you are or become pregnant, your child will become part of our plan on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us to choose a doctor for your newborn baby before he or she is born.

All newborn children will be enrolled in their mother's health plan **UNLESS** the child is in a group that cannot join managed care.

A newborn child may not be able to join managed care **IF:**

- The child is Medicaid eligible but lives with an incarcerated mother; or
- The child has access to full and cost effective, private health care coverage.

Since there may be other conditions, be sure to check with Social Services or call your health plan's member services number.

Excellus
165 Court Street, Rochester, New York 14647

We Are Here for You

For Questions or for a printed copy of the provider directory, call Member Services at 1-800-650-4359

TTY: 1-800-662-1220

You can also get a list of providers on our website at www.excellusbcbs.com