Member Handbook, and Other Important Documents

This handbook is revised for April 2025.

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: 711

Excellus

B986C May 2025

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-800-650-4359, TTY/TDD 1-800-662-1220.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-800-650-4359, TTY/TDD 1-800-662-1220.	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-800-650-4359, TTY/TDD 1-800-662-1220.	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-800-650-4359 TTY/TDD 1-800-662-1220	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-800-650-4359, TTY/TDD 1-800-662-1220. 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-800-650-4359 (TTY/TDD 1-800-662-1220).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-800-650-4359, TTY/TDD 1-800-662-1220.	Italian
ATTENTION: Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-800-650-4359 TTY/TDD 1-800-662-1220.	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-800-650-4359, TTY/TDD 1-800-662-1220.	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט . רופט 1-800-650-4359, 1-800-662-1220 TTY/TDD	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-800-650-4359, TTY/TDD 1-800-662-1220.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-800-650-4359, TTY/TDD 1-800-662-1220.	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-800-650-4359 TTY/TDD 1-800-662-1220. -এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-800-650-4359, TTY/TDD 1-800-662-1220.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-800-650-4359, TTY/TDD 1-800-662-1220.	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-800-650-4359, TTY/TDD 1-800-662-1220	Urdu

Changes to Behavioral Health Appointment Wait Times Effective July 1, 2025

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE UPDATED INFORMATION

Behavioral Health Appointment Standards

Use the following list as the **appointment standards for our limits on how long you may have to wait after your request for a behavioral health appointment**:

- Initial appointment with an outpatient facility or clinic: 10 business days
- Initial appointment with a behavioral health care professional who is not employed by or contracted with an outpatient facility or clinic: 10 business days
- Follow-up visit after mental health/substance abuse emergency room (ER) or inpatient visit: 5 business days
- Non-urgent mental health or substance abuse visit: 5 business days

If you are unable to schedule a behavioral health appointment within the appointment wait times listed above, you, or your designee, may submit an access complaint to Blue Choice Option by telephone, 1-800-650-4359 and in writing to Excellus Health Plan, Inc. PO Box 21146, Eagan, MN 55121 to resolve this issue.

If we are unable to locate a plan participating provider that can treat your behavioral health condition, you can receive a referral to a qualified out-of-network provider who can.

Behavioral Health Access Complaint

If you are unable to schedule a behavioral health appointment and if you submit a behavioral health access complaint, Blue Choice Option must provide you with the name and contact information of a provider that can treat your behavioral health condition. Blue Choice Option must provide this information within three (3) business days after receiving your complaint.

YOUR MEMBER HANDBOOK HAS BEEN UPDATED TO INCLUDE ADDITIONAL INFORMATION FOR SOCIAL CARE NETWORKS

As of **January 1, 2025**, you can receive screening and referral to existing local, state and federal services through regional Social Care Networks (SCNs). If you are eligible, these local groups can connect you to services in your community that help with housing, food, transportation, education, employment, and care management at no cost to you.

- After screening through the SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.

- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:

    - Housing and utilities support:
        - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
        - Mold, pest remediation, and asthma remediation services.
        - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
        - Providing small refrigeration units needed for medical treatment.
        - Medical Respite.
        - Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.

    - Nutrition support:
        - Getting help from a nutrition expert who will help you choose healthy foods to meet your health needs and goals.
        - Getting prepared meals, medically tailored meals, food prescriptions, fresh produce, or non-perishable grocery items.
        - Providing cooking supplies like pots, pans, utensils, a microwave, and a refrigerator to prepare meals.

    - Transportation services:
        - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting

classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

- Care management services:
  - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
  - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with an SCN in your area:

1. You may call the health plan's member services 1-800-650-4359 (TTY users 711) and we will connect you to the SCN in your area.

2. You may call the SCN serving your county and request a screening or more information. See the SCN contact information in the chart below.

3. You may also visit their website to begin a self-screening.

Once connected with the SCN, a Social Care Navigator will confirm your eligibility by asking questions, requesting supporting documentation (if necessary), tell you more about eligible services, and help you get connected to them.

SCN	Counties	Phone number
Forward Leading IPA	Allegany, Cayuga, Chemung, Genesee, Livingston, Monroe, Ontario, Orleans, Schuyler, Seneca, Steuben, Wayne, Wyoming, Yates	315-264-9991
	https://forwardleadingipa.org/welinkcare	

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Chronic Disease Self-Management Program (CDSMP) for Arthritis

If you've been diagnosed with arthritis and are interested in learning more about self-management related to this disease, Blue Choice Option covers services that may help.

Starting **June 1, 2025**, Blue Choice Option will cover the **Chronic Disease Self-Management Program (CDSMP)** for adults aged 18 years and older, which aims to increase confidence, physical and mental well-being, and knowledge to manage long term conditions.

This program may help prevent you from:

- going to the emergency room;
- being admitted into the hospital; *and/or*
- needing other medical care for your arthritis.

Each CDSMP series meets 2.5 hours once per week, for a total of six weeks.

Eligibility

You may be eligible for CDSMP for arthritis services if you have a recommendation by a physician, or other licensed practitioner, and are:

- At least 18 years old; *and*
- Diagnosed with arthritis.

Talk to your provider to see if you qualify to take part in the CDSMP for arthritis.

To learn more about these services, call Member Services at 1-800-650-4539.

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Doula Services

This is an important notice about your Medicaid Managed Care plan benefits. Please read it carefully. If you have any questions, please call us at 1-800-650-4539.

Starting **April 1, 2025**, Blue Choice Option will cover doula services during pregnancy and up to 12 months after the end of pregnancy, no matter how the pregnancy ends. Currently, members can access doula services by using their Medicaid card. Beginning **April 1, 2025**, you can use your Blue Choice Option plan card to receive doula services.

What is a Doula?

Doulas provide physical, emotional, educational, and non-medical support for pregnant and postpartum persons before, during, and after childbirth or end of pregnancy.

What Doula Services are Available?

Doula services can include up to eight (8) visits with a doula during and after pregnancy and continuous support while in labor and during childbirth. If you become pregnant within the 12 months following a prior pregnancy, your eligibility for doula services will start over with the new pregnancy. Any unused doula services from the prior pregnancy will not carry over.

Doula services may include:

- The development of a birth plan;
- Ongoing support throughout the pregnancy;
- Continuous support during labor and childbirth;
- Education and information on pregnancy, childbirth, and early parenting;
- Assisting with communication between you and your medical providers; and
- Connecting you to community-based childbirth and parenting resources.

Eligibility

If you are pregnant or have been pregnant within the last 12 months, you are eligible for doula services. You are eligible for these services with each pregnancy.

If you started to receive doula services with a Medicaid-enrolled doula(s) before April 1, 2025, your doula services will continue to be covered until 12 months after the end of your pregnancy. If you start to receive doula services on or after April 1, 2025, your doula needs to participate with Blue Choice Option.

To learn more about these services, call Member Services at 1-800-650-4539.

Electronic Notice Option

Blue Choice Option and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices to you by email.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone or mail:

Phone…….1-800-650-4539
Mail……..……...PO Box 21146, Eagan, MN 55121

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

Blue Choice Option will let you know by mail that you have asked to get notices electronically.

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE ADDITIONAL SERVICES

Starting **January 1, 2025**, you can connect to organizations in your community that provide services to help with housing, food, transportation, and care management at no-cost to you, through a regional Social Care Network (SCN).

- Through this SCN, you and your child can meet with a Social Care Navigator who can check your eligibility for services that can help with your health and well-being. They will ask you some questions to see where you might need some extra support.

- If you or your child qualify for services, the Social Care Navigator can work with you to get the support you need. You may qualify for more than one service, depending on your situation. These services include:

    - Housing and utilities support:
        - Installing home modifications like ramps, handrails, grab bars to make your home accessible and safe.
        - Repairing and fixing water leaks to prevent mold from growing in your home.
        - Sealing holes and cracks to prevent pests from entering your home.
        - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
        - Helping you find and apply for safe and stable housing in the community.

    - Nutrition support:
        - Getting help from a nutrition expert who will give you guidance and support in choosing healthy foods to meet your health needs and goals.
        - Getting prepared meals, fresh produce, or grocery items delivered to your home for up to six (6) months. These food items will be tailored to your specific health needs.
        - Providing cooking supplies like pots, pans, microwave, refrigerator, and utensils to prepare meals.

    - Transportation services:
        - Helping you with access to public or private transportation to places approved by the SCN such as: going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

- Care management services:
  - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
  - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

If you are interested, please call member services 1-800-650-4359 (TTY 711) and we will connect you to a SCN in your area. The Social Care Navigator will verify your eligibility, tell you more about these services, and help you get connected to them.

YOUR MEMBER HANDBOOK HAS BEEN CHANGED

Benefits You Can Get From Blue Choice Option OR With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your Blue Choice 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 us if you have questions at 1-800-650-4359.

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.

You can request that Blue Choice Option send any communication regarding family planning services to a different address or through a different way. To update your family planning communication preference, please call Member Services at 1-800-650-4359.

Get These Services From Blue Choice 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 midwife
- 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, and an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam, or 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 Blue Choice Option ID card to see one of our family planning providers. Check our Provider Directory or call Member Services for help in finding a provider.

- Or, you can use your Medicaid card if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services 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.

You can request that Blue Choice Option send any communication regarding family planning services to a different address or through a different way. To update your family planning communication preference, please call Member Services at 1-800-650-4359.

HERE'S WHERE TO FIND INFORMATION YOU WANT

WELCOME to Blue Choice Option Medicaid Managed Care Program

We are glad that you enrolled in Blue Choice 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 you, however, just call us at 1-800-650-4359.

How Managed Care Plans Work

The Plan, Our Providers, and You

Managed care provides a central home for your care.

- We have a group of health care providers to meet your needs. These doctors and specialists, hospitals, labs, and other health care facilities make up our **provider network**. Our provider network is listed in our **provider directory**. To get a provider directory, call 1-800-650-4359 to get a copy or visit our website at www.excellusbcbs.com.

- When you join Blue Choice Option, you will need to select a primary care provider (PCP) from our provider network. If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

- 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 and 9 for details.

Your PCP is available to you every day, day and night. If you need to speak to them after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible.

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. Blue Choice Option recognizes the trust needed between you, your family, your doctors, and other care providers. Blue Choice 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 Blue Choice Option, your Primary Care Provider, your authorized representative, and other providers who give you care. 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. Blue Choice 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 Blue Choice 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**. Use this handbook for reference or check it out a bit at a time.

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

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

Help From Member Services

There is someone to help you at Member Services. Please call Member Services at 1-800-650-4359 (TTY 711). You can reach us Mondays through Fridays from 8 a.m. to 6 p.m. You can call 1-800-650-4359 (TTY 711) 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 let us know if you are pregnant or have 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 Blue Choice Option on the day they are 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 they are born.

- We **offer free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.
- **If you do not speak English**, we can help. We want you to know how to use your health care plan no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
    - TTY machine (Our TTY phone number is 711).
    - 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 are 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 will send you a Welcome Letter. Your Blue Choice Option ID card should arrive within 14 days after your enrollment date. Your card has your PCP's name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your Blue Choice Option ID card, call us right away. Your ID card does not show that you have Medicaid or that Blue Choice 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 of Blue Choice Option. You should keep your Medicaid benefit card. You will need this card to get services that Blue Choice Option does not cover.

PART I: FIRST THINGS YOU SHOULD KNOW

How To Choose Your Primary Care Provider (PCP)

- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor, nurse practitioner, or other healthcare provider. **If you have not chosen a PCP for you and your family, you should do so right away**. If you do not choose a doctor within 30 days from when you receive your welcome packet, we will choose one for you. **You may also be able to choose a PCP at your behavioral health clinic.**

- 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 1-800-650-4359 can check to see if you already have a PCP or help you choose one.

- Our provider directory has a list of all the doctors, clinics, hospitals, labs, and others who work with Blue Choice Option. It lists the address, phone number, 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 that:
    - you have seen before
    - understands your health problems
    - is taking new patients
    - can serve you in your language
    - is easy to get to

  Women can also choose one of our OB/GYN doctors to deal with women's health care.

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

- In almost all cases, your doctors will be Blue Choice Option providers. **There are four instances when you can still see another provider that you had before you joined Blue Choice Option.** In these cases, your provider must agree to work with Blue Choice Option. You can continue to see your doctor if:
    - You are more than 3 months pregnant when you join Blue Choice Option and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care. This post-partum care continues up to 12 weeks after delivery.
    - At the time you join Blue Choice 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 Blue Choice 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.
    - At the time you join Blue Choice Option, you are being treated for a Behavioral Health condition. In most cases, you can still go to the same provider. Some people may have to choose a provider that works with the health plan. Be sure to talk to your provider about this change. Blue Choice Option will work with you and your provider to make sure you keep getting the care you need.

  Blue Choice 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**. 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** Blue Choice 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 12 weeks 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 Blue Choice 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 Care

- Regular health care means exams, regular check-ups, shots or other treatments to keep you well, advice when you need it, and referral to the hospital or specialists when needed. It means you and your 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 your PCP whenever you have a medical question or concern. If you call after hours or weekends, leave a message with 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;
    2. to deal with a danger to your life;
    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 them. 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 Blue Choice Option.

- **If you need care before your first appointment**, call your PCP's office to explain your concern. They 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
    - follow-up visit after mental health/substance abuse emergency room (ER) or inpatient visit: 5 days
    - non-urgent mental health or substance abuse visit: 1 week

- Use the following list as an **appointment guide for our limits on how long you may have to wait after your request for a perinatal appointment**:
    - first trimester: visit must occur within 3 weeks of the request for care
    - second trimester: visit must occur within 2 weeks of the request for care
    - third trimester**:** visit must occur within 1 week of the request for care
    - first newborn visit: within 2 weeks of hospital discharge
    - initial family planning visit must occur within 2 weeks of the request for care
    - for specialist referrals and urgent matters during pregnancy:
        - urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 72 hours
        - non-urgent specialist referrals must be seen as soon as clinically indicated, not to exceed 2 to 4 weeks of when the request was made
        - for non-emergent, but urgent matters**,** pregnant persons must be seen within 24-hours of request for care

How To Get Specialty Care – Referrals

- If you need care that your PCP cannot give, they 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 Blue Choice Option providers. Talk with your PCP to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask Blue Choice 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

Blue Choice Option for approval *before* you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you are not responsible for any of the costs except any co-payments as described in this handbook.

- To request to see a specialist outside the Blue Choice Option 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 Blue Choice 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 43 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 a Blue Choice 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 43 to find out how.
- You may access providers in Blue Choice 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 Blue Choice 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
    - a referral to a specialty care center that deals with the treatment of your illness
    - a call to Member Services for help in getting access to a specialty care center

Get These Services From Blue Choice 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 midwife
- 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, and an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam, or 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* Blue Choice Option *ID card* to see one of our family planning providers. Check our Provider Directory or call Member Services for help in finding a provider.

- Or, you can *use your Medicaid card* if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services 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 Sexually Transmitted Infection (STI) Screening

Everyone should know their HIV status. HIV and STI 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 an 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 provider. 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 our providers, you can use your Medicaid card to see a family planning provider outside the Blue Choice Option network. For help in finding either a Plan 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 of an ophthalmologist, optometrist and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Members diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period. You must choose one of our participating providers.

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

Behavioral Health – (Mental Health and Substance Use)

We want to help you get the mental health and substance use services you 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 or recently had a baby 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 an average person fear that they, or someone, will suffer serious harm without care right away.

Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop
- 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
- 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 your plan's or your PCP's approval before getting emergency care, and you are not required to use our hospitals or doctors.

- **If you're not sure, call your PCP or Blue Choice 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. If you are discharged from the emergency room with prescriptions, they must be filled at an NYRx Medicaid-enrolled pharmacy.

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 Blue Choice Option 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 earache who wakes up in the middle of the night and won't stop crying.
- This could be the flu or if you need stitches.
- 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:

- Stop smoking classes
- Prenatal care and nutrition
- Grief / loss support
- Chest 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
- Other classes for you and your family

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.

Electronic Notice Option

Blue Choice Option and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail.

We can send you these notices to you by email.

If you want to get these notices electronically, you must ask us.

To ask for electronic notices contact us by phone or mail:

Phone 1-800-650-4359

Mail ..... PO Box 211256, Eagan, MN 55121

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

Blue Choice Option will let you know by mail that you have asked to get notices electronically.

PART II: YOUR BENEFITS AND PLAN PROCEDURES

BENEFITS

Medicaid Managed Care provides a number of services you get in addition to those you get with regular Medicaid. Blue Choice Option will provide or arrange for most services that you will need. You can get a few services without going through your PCP. These include emergency care, family planning, HIV testing and counseling, and specific self-referral services. Please call our member services department at 1-800-650-4359 if you have any questions or need help with any of the services below.

Services Covered By Blue Choice Option

You must get these services from the providers who are in Blue Choice Option. All services must be medically or clinically necessary and provided or referred by your PCP (Primary Care Provider). Please call our Member Services department 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 members from birth up to age 21
- smoking cessation counseling
- access to free needles and syringes
- smoking cessation counseling
- HIV education and risk reduction

Maternity Care

- pregnancy care
- doctors/midwife and hospital services
- newborn nursery care

Home Health Care

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

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

- Must be medically needed and arranged by Blue Choice 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 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 Health Care Services

- Must be recommended by your PCP
- Provides health education, nutrition, nursing and social services, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care

AIDS Adult Day Health Care Services

- Must be recommended by your PCP
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational and wellness/health promotion activities

Therapy for Tuberculosis (TB)

- 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 Blue Choice 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 this benefit, you can call our Member Services Department at 1-800-650-4359.

Dental Care

Blue Choice 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, an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleanings, x-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you.

In certain circumstances, Blue Choice Option may cover additional services, such as:

- Dentures
- Implants
- Crowns
- Root Canals

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 or you can access the directory on www.excellusbcbs.com . 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 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 1-866-795-6493 or please call Blue Choice Option at 1-800-650-4359. Member Services Representatives are there to help you.
- 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 1-866-795-6493 for more help.

Orthodontic Care

Blue Choice 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 palate, or cleft lip.

Vision Care

- Services of an ophthalmologist, ophthalmic dispenser and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- Eye exams, generally every two years, unless medically needed more often
- Glasses (new pair of Medicaid approved frames every two years, or more often if medically needed)
- Low vision exam and vision aids ordered by your doctor
- Specialist referrals for eye diseases or defects
- Members diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12 month period

Hospital Care

- Inpatient care
- Outpatient care
- Lab tests, x-rays, and other necessary 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 page 12

Specialty Care

Includes the services of other practitioners, including:

- physical therapist
- occupational and speech therapists
- audiologist
- midwives
- cardiac rehabilitation
- podiatry if medically needed

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 Blue Choice Option;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with daily living, physical therapy, occupational therapy, and speech-language pathology

Rehabilitation:

Blue Choice Option covers short term, or rehabilitation (also known as “rehab”) stays, in a skilled nursing home facility.

Long Term Placement:

Blue Choice Option covers long term placement in a nursing home facility for members 21 years of age and older.

Long term placement means you will live in a nursing home.

When you are eligible for long term placement, you may select one of the nursing homes that are in Blue Choice Option’s network that meets your needs. Call 1-800-650-4359 for help finding a nursing home in our network.

If you want to live in a nursing home that is not part of Blue Choice Option’s network, you must transfer to another plan that has your chosen nursing home in its network.

Eligible Veterans, Spouses of Eligible Veterans, and **Gold Star Parents of Eligible Veterans** may choose to stay in a Veterans' nursing home.

Blue Choice Option does not have a Veterans' Home in its network. If you are an eligible Veteran, spouse of an eligible Veteran or a Gold Star Parent of an eligible Veteran and you want to live in a Veterans' Home, we will help arrange your admission. You must transfer to another Medicaid Managed Care health plan that has the Veterans' Home in its network.

Determining Your Medicaid Eligibility for Long Term Nursing Home Services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or Blue Choice Option pay for long term nursing home services. The LDSS will review your income and assets to determine your eligibility for long term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

Additional Resources

If you have concerns about long term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org

- New York State Office for the Aging
    - Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501

    - NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov

- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights/

BEHAVIORAL HEALTH CARE

Behavioral health care includes mental health and substance use treatment and rehabilitation services. All of our members have access to behavioral health services which include:

Adult Mental Health Care

- Psychiatric services
- Psychological services
- Inpatient and outpatient mental health treatment
- Injections for behavioral health related conditions
- Rehab services if you are in a community home or in family-based treatment
- Individual and group counseling through Office of Mental Health (OMH) clinics

Adult Outpatient Mental Health Care

- Continuing Day Treatment (CDT)
- Partial Hospitalization (PH)Adult Outpatient Rehabilitative Mental Health Care
- Assertive Community Treatment (ACT)
- Personalized Recovery Oriented Services (PROS)

Adult Mental Health Crisis Services

- Comprehensive Psychiatric Emergency Program (CPEP) including extended observation bed
- Crisis intervention services
    - Mobile Crisis and Telephonic Crisis Services
- Crisis Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Substance Use Disorder Services for Adults age 21+

- Crisis Services/Detoxification
    - Medically Managed Withdrawal and Stabilization Services
    - Medically Supervised Inpatient Withdrawal and Stabilization Services
    - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
    - Stabilization
    - Rehabilitation
    - Reintegration
- Outpatient Addiction Treatment Services
    - Outpatient Clinic
        - Intensive Outpatient Treatment
        - Ancillary Withdrawal Services
        - Medication Assisted Treatment
    - Outpatient Rehabilitation Services
    - Opioid Treatment Programs (OTP)
- Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs
    - Blue Choice Option covers Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.
    - You can get Gambling Disorder Treatment:
        - face-to-face; or
        - through telehealth.
    - If you need Gambling Disorder Treatment, you can get it from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program.
    - You do not need a referral from your PCP to get these services. If you need help finding a provider, please call the Blue Choice Option member services at the number listed below.

Harm Reduction Services

If you need help related to a substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. Blue Choice 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.

Mental Health Care for Individuals Under Age 21

All eligible children under age 21:

- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation bed
- Partial hospitalization (PH)
- Inpatient psychiatric services
- Individual and group counseling through OMH clinics
- Children and Family Treatment and Support Services (CFTSS), including:
    - Other Licensed Practitioner (OLP)
    - Psychosocial Rehabilitation (PSR)
    - Community Psychiatric Supports and Treatment (CPST)
    - Family Peer Support Services (FPSS)
    - Crisis Intervention (CI)
    - Youth Peer Support (YPS)
- Psychiatric services
- Psychological services
- Injections for behavioral health related conditions
- Children's Crisis Residence: This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

Mental Health Services for Eligible children under age 21 (ages18-20):

- Assertive Community Treatment (ACT)
- Continuing Day Treatment (CDT)
- Personalized Recovery Oriented Services (PROS)
- Crisis Residential Programs:
    - Residential Crisis Support: This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.
    - Intensive Crisis Residence: This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Substance Use Disorder Care for Individuals Under Age 21

- Crisis Services/Detoxification
    - Medically Managed Withdrawal and Stabilization Services
    - Medically Supervised Inpatient Withdrawal and Stabilization Services
    - Medically Supervised Outpatient Withdrawal and Stabilization Services
- Inpatient Rehabilitation Services
- Residential Addiction Treatment Services
    - Stabilization
    - Rehabilitation
    - Reintegration
- Outpatient Addiction Treatment Services
    - Outpatient Clinic
        - Intensive Outpatient Treatment
        - Ancillary Withdrawal Services
        - Medication Assisted Treatment
    - Outpatient Rehabilitation Services
    - Opioid Treatment Programs (OTP)

Children's Home and Community Based Services

New York State covers Children's Home and Community Based Services (HCBS) under the children's waiver. Blue Choice Option covers children's HCBS for members participating in the children's waiver and provides care management for these services.

Children's HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS are provided where children/youth and families are most comfortable and supports them as they work towards goals and achievements.

Who can get Children's HCBS?

Children's HCBS are for children and youth who:

- Need extra care and support to remain at home/in the community
- Have complex health, developmental and/or behavioral health needs
- Want to avoid going to the hospital or a long-term care facility
- Are eligible for HCBS and participate in the children's waiver

Members under age 21 will be able to get these services from their health plan:

- Community habilitation
- Caregiver/ Family Advocacy and Support Services
- Prevocational services - *must be age 14 and older*
- Supported employment - *must be age 14 and older*
- Respite services (planned respite and crisis respite)
- Palliative care
    - Expressive Therapy
    - Massage therapy
    - Bereavement Service
    - Pain and Symptom Management
- Non-medical Transportation

Members under age 21 will access the following services through designated health homes using your Medicaid card:

- Environmental Modifications
- Vehicle Modifications
- Adaptive and Assistive Technology
- Transitional Care Coordination
- Transitional Services

Children/youth participating in the Children's Waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. Blue Choice Option will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), Blue Choice Option will work with C-YES and provide your care management.

Article 29-I Voluntary Foster Care Agency (VFCA) Health Facility Services

Blue Choice Option covers Article 29-I VFCA Health Facility services for children and youth under age 21.

29-I VFCA Health Facilities work with families to promote well-being and positive outcomes for children in their care. 29-I VFCA Health Facilities use trauma informed practices to meet the unique needs of each child.

29-I VFCA Health Facilities may only serve children and youth referred by the local district of social services.

Core Limited Health-Related Services

1. Skill Building
2. Nursing Supports and Medication Management
3. Medicaid Treatment Planning and Discharge Planning
4. Clinical Consultation and supervision
5. Managed Care Liaison/Administration

and

Other Limited Health-Related Services

1. Screening, diagnosis, and treatment services related to physical health
2. Screening, diagnosis, and treatment services related to developmental and behavioral health
3. Children and Family Treatment and Support Services (CFTSS)
4. Children's Home and Community Based Services (HCBS)

Health Home Care Management

Blue Choice Option wants to meet all of your health needs. If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your health care;

- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Help with appointments with your PCP and other providers; and
- Help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, contact Member Services at 1-800-650-4359.

Infertility Services
If you are unable to get pregnant, Blue Choice Option covers services that may help.

Blue Choice Option will cover the coordination of care related to limited infertility drugs covered by the Medicaid pharmacy program. The infertility benefit includes:

- Office visits
- X-ray of the uterus and fallopian tubes
- Pelvic ultrasound
- Blood testing

Eligibility

You may be eligible for infertility services if you meet the following criteria:

- You are 21-34 years old and are unable to get pregnant after 12 months of regular, unprotected sex.
- You are 35-44 years old and are unable to get pregnant after 6 months of regular, unprotected sex.

National Diabetes Prevention Program (NDPP) Services

If you are at risk for developing Type 2 diabetes, Blue Choice Option covers services that may help.

Blue Choice Option covers diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The **National Diabetes Prevention Program** is an educational and support program designed to assist at-risk people from developing Type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and are:

- At least 18 years old,
- Not currently pregnant,
- Overweight, and
- Have not been previously diagnosed with Type 1 or Type 2 Diabetes.

And, you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, **or**
- You have been previously diagnosed with gestational diabetes, **or**
- You score 5 or higher on the CDC/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP.

Applied Behavior Analysis (ABA) Services

Blue Choice Option covers Applied Behavior Analysis (ABA) therapy provided by:

- Licensed Behavioral Analyst (LBA), or
- Certified Behavioral Analyst Assistant (CBAA) under the supervision of an LBA.

Who can get ABA?

Children/youth under the age of 21 with a diagnosis of autism spectrum disorder and/or Rett Syndrome. If you think you are eligible to get ABA services, talk to your provider about this service. Blue Choice Option will work with you and your provider to make sure you get the service you need.

The ABA services include:

- assessment and treatment by a physician, licensed behavioral analyst, or certified behavior analyst assistant,
- individual treatments delivered in the home or other setting,
- group adaptive behavior treatment, and
- training and support to family and caregivers.

Gender Dysphoria Related Care and Services

Blue Choice Option covers the following gender dysphoria related care and services:

- Gender Reassignment (sex change) Surgeries, Services, and Procedures,
- Puberty Suppressants (medications used to delay the effects of puberty), and
- Cross-Sex Hormone Therapy (hormone medications used to help with sex change).

What is Gender Dysphoria?

Gender Dysphoria is the feeling of discomfort or distress that might occur when there is a conflict between the sex you were assigned at birth and the gender you identify with.

Gender Reassignment Surgery

Prior to surgery for the treatment of gender dysphoria, you must:

- receive a medical necessity determination from a qualified medical professional,
- be 18 years of age or older. Members under 18 years of age will be reviewed on a case-by-case basis for medical necessity and must receive prior approval from Blue Choice Option, as applicable.
- have lived in a gender role consistent with your gender identity for 12 months. During this time, you must have received behavioral health counseling, as deemed necessary by your treating qualified medical professional, and
- have two letters from qualified New York State licensed health professionals recommending surgery based upon their own assessment.

Puberty Suppressants and Cross-Sex Hormones

Blue Choice Option will provide medically necessary hormone therapy for treatment of gender dysphoria.

Treatment with puberty suppressants, must be:

- based upon a determination from a qualified medical professional.

Treatment with cross-sex hormones, must meet the following age specific criteria:

- members 16 years of age or older must receive a determination of medical necessity made by a qualified professional.
- members 16 and 17 years of age must also receive a determination from a qualified medical professional that you are eligible and ready for treatment.
- members under 16 years of age, must meet the above criteria and receive prior approval from Blue Choice Option, as applicable.

Talk to your health care provider to see if you qualify for gender dysphoria related care and services. To learn more about these services, call Member Services at 1-800-650-4359.

In Lieu of Services (ILS)

ILS are services or settings that are not covered by Medicaid but are medically appropriate substitutes for covered services or settings.

Medically Tailored Meals Services

We're proud to offer benefits and services that help you live a healthy life. Our no-cost Medically Tailored Meals program provides healthy meals straight to your home.

Through this program, you and other members who qualify can get:

- Help from a registered dietitian and nutritionist. This person is a food and nutrition expert and will help give guidance and support in choosing healthy foods.
- Up to two meals per day delivered to your home for six months at a time.

You may be able to continue receiving meals as long as you are eligible for this program. These meals are tailored for your specific health needs and can help you gain access to healthy, nutritious foods.

This program is offered to Blue Choice Option members who are 18 years of age or older. Members must have a secure place to store and heat meals and have cancer, diabetes, heart failure, or HIV/AIDS, and a certain number of inpatient hospital stays and/or emergency room (ER) visits within the last 12 months related to these conditions.

Our Intake team will call you if you are eligible. You can as well call Member Service at 1-800-650-4359 for more information.

Joining this program is up to you. If you decide not to join, it will not affect your Medicaid eligibility or benefits.

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
- Court Ordered Services
- Case Management
- Help getting social support services
- Federally Qualified Health Centers (FQHC)

Benefits You Can Get From Blue Choice Option *OR* With Your Medicaid Card

For some services, you can choose where to get the care. You can get these services by using your Blue Choice 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 us if you have questions at 1-800-650-4359.

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 (when receiving this service as part of a family planning visit)

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 an HIV or STI test any time you have family planning services. You do not need a referral from your PCP. Just make an appointment with any family planning provider. 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.
- If you'd rather not see one of our Blue Choice Option providers, you can use your Medicaid card to see a family planning provider outside Blue Choice Option. For help in finding either a Plan 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.

You can ask your PCP for a list of places to get these services or call Member Services at 1-800-650-4359.You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for nearby places to get these services.

Tuberculosis (TB) Diagnosis and Treatment

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

Benefits Using Your MEDICAID CARD Only

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

Pharmacy

You can get prescriptions, over-the-counter medicines, enteral formulas, and some medical supplies from any pharmacy that takes Medicaid. A co-payment may be required for some people, for some medications and pharmacy items.

Certain medications may require that your doctor get prior authorization from Medicaid before the pharmacy can dispense your medication. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

Do you have questions or need help? The Medicaid Helpline can assist you. They can talk to you in your preferred language. They can be reached at 1-800-541-2831(TTY 711).

They can answer your call:

- Monday - Friday, 8 am – 8pm
- Saturday, 9am – 1 pm

Transportation

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 1-866-932-7740. 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.

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

Note: For undocumented non-citizens aged 65 and over, non-emergency transportation is not covered.

Developmental Disabilities

- Long-term therapies
- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program

Services NOT Covered:

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

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider that is not part of Blue Choice Option, unless it is a provider you are allowed to see as described elsewhere in this handbook or Blue Choice Option or your PCP send you to that provider
- Services for which you need a referral (approval) in advance and you did not get it.
- Drugs when used to treat erectile dysfunction or sexual dysfunction

You may have to pay for any service 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 Blue Choice Option

If You Get a Bill

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

You have the right to ask for a plan appeal if you think you are being asked to pay for something Medicaid or Blue Choice Option should cover. See the Plan Appeal section later in this handbook.

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

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, your provider, 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 cosmetic surgery
- Select Ancillary Services- i.e. Prosthetics, Orthopedic Devices and DME
- Home Health Care including Home Infusion Nursing and Therapy
- Inpatient Admissions
- 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
- Select Laboratory Services
- New Technology and Treatments
- Radiation Oncology Treatment
- Cardiac Device Implantation
- Select Behavioral Health Services
- Long Term Services and Supports
- Some Drugs

Asking for approval of a treatment or service is called a **service authorization request**.

To get approval for these treatments or services you or your doctor 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:

Blue Choice Option has a review team to be sure you get the services you need. 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 the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

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 use to make 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 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 within 3 work days of when we have all the information we need, but no later than 7 days after we receive your request. We will tell you by the 7th 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 no later than 7 days after we receive your request. We will tell you by the 7th 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 inpatient rehabilitation services after an inpatient hospital admission, we will make a decision within 1 work day of when we have all the information we need, but no later than 7 days after we receive your request. We will tell you by the 7th day if we need more information.
- 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 a practitioner administered drug when provided in an outpatient hospital, clinic, or doctor’s office, we will make a decision within 24 hours of your request, after your health care provider has provided Blue Choice Option with a completed prior authorization form with all necessary information included to review the 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 practitioner administered drugs when provided in an outpatient hospital, clinic, or physician’s office, after your health care provider has provided Blue Choice Option with a completed prior authorization form with all necessary information included to review the 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 your representative may also ask us to take more time to make a decision. This may be because you have more information to give us 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 Blue Choice Option 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 Appeals section later in this handbook.*

Other Decisions About Your Care:

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we 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** Blue Choice Option **or by Medicaid even if we later deny payment to the provider**.

How Our Providers Are Paid

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

- Most PCPs who work in a clinic or health center, get a **salary.** The number of patients they see does not affect their salary.
- PCPs who work from their own offices may get a set fee each month for each patient for whom they are the PCP. The fee stays the same regardless of the number of times the patient visits the PCP. This is called **capitation.**
- Providers may get a set fee for each person on their patient list, but some money may be held back for an **incentive** fund. At the end of the year, PCPs who have met the incentive standards set by Blue Choice Option receive additional payments.
- Providers may also receive **regular Medicaid payment**. This means they get a set fee for each service they provide.

You Can Help With Plan Policies

You can help us develop policies that best serve our members. If you have ideas, please tell us about them. Please let us know if you would 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.

Additional 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 the Excellus BlueCross and 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 Blue Choice Option
- How we keep your medical records and member information private
- In writing, we will tell you how Blue Choice 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 Blue Choice Option
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of Blue Choice 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, you *may* be able to enroll in another program. Contact your local Department of Social Services, or NY State of Health, The Official Health Plan Marketplace, at 1-855-355-5777 or nystateofhealth.ny.gov.

Disenrollment And Transfers

If YOU Want to Leave Blue Choice Option

You can try us out for 90 days. You may leave Blue Choice 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 Blue Choice Option for nine more months, unless you have a good reason (good cause) to leave our Plan.

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, Blue Choice Option, and the LDSS all agree that disenrollment is best for you
- You are or become exempt or excluded from managed care
- We have not been able to provide services to you as we are required to under our contract with the State
- You are a child that has entered foster care at the LDSS or 29-I VFCA Heath Facility and disenrollment from the plan is in your best interest

To change plans:

If you've enrolled through your local Department of Social Services (LDSS):

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

If you've enrolled through NY State of Heath:

- Log your NY State of Health account at www.nystateofhealth.ny.gov, or
- Meet with an enrollment assistor to receive assistance with updating your account, or
- Call the NY State of Health Customer Service Center at 1-855-355-5777 (TTY 711).

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. Blue Choice Option will provide the care you need until then.

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

You Could Become Ineligible for Blue Choice Option

You or your child may have to leave Blue Choice Option if you or the child:

- move out of the County or service area
- change to another managed care plan
- have access to an HMO or other insurance plan through work
- go to prison, or
- otherwise lose Medicaid eligibility

Your child may have to leave Blue Choice Option if they:

- Join a Physically Handicapped Children's Program
- **If you have to leave Blue Choice 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.

We Can Ask You to Leave Blue Choice Option

You can also lose your Blue Choice Option membership if you often:

- refuse to work with your PCP regarding your care,
- don't follow Blue Choice Option's 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 our 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 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
- Member ID 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 ..... 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 ..... 165 Court St., Rochester, NY 14647

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 an 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.

  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*.

- If 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. a recommendation to 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 Blue Choice 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 in 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:

- 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**
- 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**
- your request was denied when you asked for home health care after you were in the hospital; **or**
- 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 Blue Choice Option to help decide your case. This can be done by calling 1-800-650-4359 or by writing.

You or your representative can file a complaint with Blue Choice Option 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.

The original denial will be reversed and your service authorization request will be approved if we do not decide your Plan Appeal on time and we said the service you are asking for is:

1. not medically necessary, or
2. experimental or investigational, or
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.

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
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 (NYS) 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 NYS. These reviewers are qualified people approved by NYS. 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 Blue Choice Option may agree to skip our appeals process and go directly to External Appeal **or**
- You can prove Blue Choice Option did not follow the rules correctly when processing your Plan Appeal

You have **4 months** after you receive Blue Choice Option's Final Adverse Determination to ask for an External Appeal. If you and Blue Choice Option agreed to skip our 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 Blue Choice Option 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 your 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 Blue Choice 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 Blue Choice Option. If we agree 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
    - deny care you wanted
    - deny payment for care you received
    - 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 – 1-800-342-3334
2. By fax – 518-473-6735
3. By internet – 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
5. In Person
   For non-New York City residents
   Office of Temporary and Disability Assistance
   Office of Administrative Hearings
   40 North Pearl Street
   Albany, New York 12243

   For New York City residents
   Office of Temporary and Disability
   Assistance Office of Administrative Hearings
   5 Beaver Street New York, New York 10004

When you ask for a Fair Hearing about a decision Blue Choice Option made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. We 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 Blue Choice Option. 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 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 by phone at 1-800-206-8125; by mail: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237; or by e-mail: ManagedCareComplaint@Health.NY.Gov .

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

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. 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 the Member Services number at 1-800-650-4539 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 Blue Choice 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 within 45 days from when we have all the information we need to answer your complaint. 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 within 48 hours from when we have all the information we need to answer your complaint. 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. 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 to complete.
- 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 Blue Choice Option.

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

Member Rights And Responsibilities

Your Rights

As a member of Blue Choice Option, you have a right to:

- Be cared for with respect, without regard for health status, gender, race, color, religion, national origin, age, marital status or sexual orientation
- Be told where, when and how to get the services you need from Blue Choice Option, including providers, hours open, benefits, and member rights and responsibilities
- Be told by your provider what is wrong, what can be done for you, and what will likely be the result in language you understand
- Get a second opinion about your care
- Help create and Give your OK to any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record, and talk about it with your provider, 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 Blue Choice Option complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated
- Use the New York 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
- Give feedback about Blue Choice Option’s member rights and responsibilities

Your Responsibilities

As a member of Blue Choice Option you agree to:

- Work with your PCP to guard and improve your health
- Tell your providers about any changes in your health, address, and telephone number
- Find out how your health care system works
- Listen to your provider'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 to receive yourself
- Tell us if you have problems with any health care staff. Call Member Services
- Keep your appointments. If you must cancel an appointment, 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

Advance Directives

There may come a time when you are not able to 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 do not want
- Second, you can appoint an adult you trust to make decisions for you
- Third, it is best to put your thoughts in writing

Health Care Proxy

A health care proxy form allows you to name another adult that you trust (usually a family member or a friend) to make decisions about your medical care if you are not able to make your own decisions. You should talk with the person you chose so they know about your wishes. To get Health Care Proxy forms, talk to your provider or go to www.health.ny.gov/forms

Do Not Resuscitate (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 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

Your PCP ..... _____

Your nearest emergency room ..... _____

Blue Choice Option

Member Services 1-800-650-4359
Member Services TTY/TDD 1-800-662-1220

After Hours

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

New York State Department of Health (complaints) 1-800-206-8125
New York State Office of Mental Health Complaints 1-800-597-8481
New York State Office of Addiction Services and
Supports (OASAS) Complaints 1-518-473-3460

Ombudsman: CHAMP 1-888-614-5400
Mailbox (Ombuds@oasas.ny.gov)

Local Department of Social Services (DSS) Addresses and Phone Numbers

Livingston County DSS:
1 Murray Hill Drive, Mt. Morris, NY 14510-1699 1-585-243-7300

Monroe County DSS:
111 Westfall Road, Rochester, NY 14620-4686 1-585-753-2740

Ontario County DSS:
3010 County Complex Drive, Canandaigua, NY 14424-1296 1-585-396-4060
for outside the County area 1-877-814-6907

Seneca County DSS:
1 DiPronio Drive, P.O. Box 690, Waterloo, NY 13165-0690 1-315-539-1800

Wayne County DSS:
77 Water Street, P.O. Box 10, Lyons, NY 14489-0010.....1-315-946-4881

Yates County DSS:
417 Liberty Street, Suite 2122, Penn Yan, NY 14527-1118 1-315-536-5183

New York Medicaid Choice……1-800-505-5678

New York State HIV/AIDS Hotline.....1-800-541-AIDS(2437)
Spanish.....1-800-233-SIDA(7432)
TDD……..1-800-369-AIDS (2437)

New York State Office of Mental Health (OMH) Complaints.....……1-800-597-8481

New York City HIV/AIDS Hotline (English & Spanish)..... 1-800-TALK-HIV (8255-448)

HIV Uninsured Care Programs..... 1-800-542-AIDS (2437)

TDD..... Relay, then 1-518-459-0121

Child Health Plus……1-800-698-4543
- Free or low-cost health insurance for children (TTY) 1-877-898-5849

Partner Assistance Program 1-800-541-AIDS (2437)
- In New York City (CNAP).....1-212-693-1419

Social Security Administration 1-800-772-1213

New York State 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

Local Pharmacy..... _____

Other Health Providers:

Important Web Sites

Blue Choice Option
https://www.excellusbcbs.com

New York State Department of Health (DOH):
https://www.health.ny.gov/

New York State Office of Mental Health (OMH):
https://omh.ny.gov/

New York State Office of Addiction Services and Supports (OASAS):
https://oasas.ny.gov/

New York State DOH HIV/AIDS Information:
https://www.health.ny.gov/diseases/aids/

Member Services: 1-800-650-4359 Crisis Line: 1-800-650-4359 TTY: 711

New York State HIV Uninsured Care Programs:
http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm

HIV Testing Resource Directory:
https://www.health.ny.gov/diseases/aids/consumers/testing/index.htm

New York City Department of Health & Mental Hygiene (DOHMH):
https://www.nyc.gov/site/doh/index.page

New York City DOHMH HIV/AIDS Information:
https://www.nyc.gov/site/doh/health/health-topics/aids-hiv.page

Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org

Excellus
An independent licensee of the Blue Cross Blue Shield Association

165 Court Street
Rochester, New York 14647

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can access this information. This notice was originally effective as of April 14, 2003, and has been revised as of October 20, 2025 to reflect updates in our privacy practices. **Please review it carefully.**

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. In addition, certain federal and state laws require that we limit how we disclose certain information considered sensitive in nature, such as HIV/AIDS, mental health, substance use disorder, and sexually transmitted diseases. Unless otherwise permitted under applicable laws, we will not disclose such sensitive information without your written consent and will follow more stringent protections where required by law. You may revoke an authorization or consent, referenced above, in writing by completing a cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization or consent before your cancellation form was processed.

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.

Treatment: 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 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 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: 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, we will only disclose the minimum amount necessary.

To Our Business Associates: 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: 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 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 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 for them to carry out their duties.

Organ Donation: 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 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 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 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 if we are in compliance with federal privacy laws.

Process and Proceedings: 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 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 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: 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 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 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: 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.

Substance Use Disorder (SUD): We will not use or disclose your PHI that includes SUD information from programs covered under 42 CFR Part 2 in any legal proceeding against you unless you give written

consent or a court order meeting specific legal requirements is obtained.

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. 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. You may contact us using the telephone number on the back of your member card to obtain a form to be completed and returned to us.

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. 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. To request a disclosure accounting you may contact us using the telephone number on the back of your member card to obtain a form to be completed and returned to us.

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 member 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 member 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.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the contact information below.

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 below. You also may submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with the address for the U.S. Department of Health and Human Services.

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 member card.

Privacy Complaints:

Contact Office: Corporate Privacy Officer

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

Phone: 1-866-584-2313

E-mail: privacy.officer@excellus.com

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

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

TTY: 711