



NHP

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HEALTH[®]
PROVIDERS



FAMILY HEALTH PLUS MEMBER HANDBOOK



MANUAL DE MEMBRESÍA

1-800-826-6240
www.getnhp.com



¡Nosotros Los Protegemos!



HERE'S WHERE TO FIND INFORMATION YOU WANT

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WELCOME TO NEIGHBORHOOD HEALTH PROVIDERS FAMILY HEALTH PLUS PROGRAM

We are glad that you chose Neighborhood Health Providers. We want to be sure you get off to a good start as a new Family Health Plus (FHPlus) member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call us at 1-800-826-6240.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

- No doubt you have seen or heard about the changes in health care. Many people now get their health benefits through managed care. Many counties in New York State, including New York City, offer a choice of FHPlus managed care health plans. In some counties, however, there may only be one plan that offers FHPlus. Under FHPlus, people must join a managed care health plan in order to be able to receive health care benefits.
- Neighborhood Health Providers has a contract with the State Department of Health to meet the health care needs of people in FHPlus. In turn, we choose a group of health care providers to help us meet your needs. These doctors and specialists, hospitals, labs and other health care facilities make up our "provider network." You'll find a list in our provider directory. If you don't have a provider directory, call Member Services to get a copy.
- When you join our plan, one of our plan providers takes care of you. Most of the time that person will be your PCP (Primary Care Provider). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you everyday, day and night. If you need to speak to him or her after hours or weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can "self-refer" to certain doctors for some services. See page 9 for details.

HOW TO USE THIS HANDBOOK

- This handbook will help tell you how your new health care system will work and how you can get the most from Neighborhood Health Providers. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.
- The first part of this handbook will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.
- When you have a question, check this Handbook or call our Member Services unit. You can also call the managed care staff at your local Department of Social Services. Be sure to tell them you are in the FHPlus Program.
- 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:

Twenty-four (24) seven (7) days a week to assist you at 1-800-826-6240,
TTY 1-800-662-1220

- You can call to get help **anytime you have a question**. You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report a pregnancy or the birth of a new baby, or **ask about any change that might affect your benefits** (for example, you get a job that offers health care coverage).
- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.
- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with communications devices. Also, we have services like:
 - TTY/TDD machine 1-800-662-1220
 - Information in Large Print
 - Case Management
 - Help in Making or Getting to Appointments
 - Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your Neighborhood Health Providers 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 it's wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid Benefit ID card (also known as the Common Benefit Identification Card.). You will need this card to get pharmacy services. All the benefits that FHPlus covers can be accessed using your plan ID card.

PART I - FIRST THINGS YOU SHOULD KNOW

HOW TO CHOOSE YOUR PCP

- You may have already picked your PCP to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP, you should do so right away.** If you do not choose a PCP within 30 days, we will choose one for you. Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services can help you choose a PCP.
- With this Handbook, you should have a **provider directory**. This is a list of all the doctors, clinics, hospitals, labs, and others who work with Neighborhood Health Providers. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

- who you have seen before,
 - who understands your health problems,
 - who is taking new patients,
 - who can serve you in your language, or
 - who is easy to get to
- Women can also choose one of our **OB/GYN** doctors to deal with women's health issues. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine check ups (twice a year), follow-up care if there is a problem, or regular care during pregnancy.
 - We also contract with **FQHCs** (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with. Just call Member Services at 1-800-826-6240 for help. Please see the list of participating FQHCs in your NHP provider directory.
 - In almost all cases, your doctors will be Neighborhood Health Providers' providers. **There are two instances when you can still see another doctor that you had before you joined Neighborhood Health Providers.** In both cases, however, your doctor must agree to work with Neighborhood Health Providers.
 1. You are more than 3 months pregnant when you join and you are getting prenatal care. In that case, you can keep your doctor until after your delivery and follow up care.
 2. At the time you join, you have a life threatening disease or condition that gets worse with time. In that case, you can ask to keep your doctor for up to 60 days.

- If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to **choose a specialist to act as your PCP**. If you would like to select a specialist as your primary care doctor to treat your long term health problem, you can make a request by calling Member Services at 1-800-826-6240. The specialist must be a participating specialist in our network. Once we get your request, we may call the specialist to obtain medical information. Once we get that information, our Medical Director will review your request. Member Services will contact you back in three (3) business days of receipt of all the information but no more than fourteen (14) days from your request. You will also receive our decision in writing.
- 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. If you wish to change your PCP after six (6) months, you can call Member Services at 1-800-826-6240 and speak with a representative who can help you select another PCP. If you wish to change your PCP before six (6) months, you can provide us with the information that supports a good reason to change your PCP before six (6) months. Once the PCP selection is made and confirmed you will receive another ID card in the mail with your new PCP. You can also change your OB/GYN or a specialist to which your PCP has referred you.
- If your **provider leaves Neighborhood Health Providers**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with Neighborhood Health Providers during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-826-6240.

HOW TO GET REGULAR CARE

"Regular 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 him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

- Your care must be "**medically necessary**". The services you get must be needed:
 - to prevent, or diagnose and correct what could cause more suffering, or
 - to deal with a danger to your life, or
 - to deal with a problem that could cause illness, or
 - 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. Your PCP will need to know as much about your medical history as you can tell him or her. If you can, prepare for your first appointment. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.
- If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the "first" appointment.)
- Use the following list as an appointment guide for our limits on how long you may have to wait after your request for an appointment:
 - your first appointment and routine physicals: within 12 weeks
 - urgent care: within 24 hours
 - non-urgent sick visits: within 3 days
 - routine, preventive care: within 4 weeks
 - first pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
 - first family planning visit: within 2 weeks
 - follow-up after a behavioral health ER or inpatient visit: 5 days
 - non-urgent behavioral health visit: 2 weeks.

HOW TO GET SPECIALTY CARE - REFERRALS

- If you need care that your PCP cannot give, he or she will **refer** you to a specialist who can. If your PCP refers you to another doctor, you are not responsible for any costs except the usual co-payments as described later in this handbook. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think the specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask our plan to approve before you can get them. Your PCP will be able to tell you what they are.
- If we do not have a specialist in our plan who can give you the care you need, we will get you the care you need from a specialist outside our plan. If your PCP determines that we do not have a specialist to provide the care you need, your PCP can call the Care Management Department at 1-800-765-3805 to ask for an exception to see a specialist outside of Neighborhood Health Providers. You may also contact Member Services at 1-800-826-6240 to make this request. We will obtain the necessary information from your PCP and have the Medical Director review the request. We will provide a decision within three (3) days of receipt of all the necessary information but no more than fourteen (14) days from your initial request. You will receive a phone call within one (1) day of our decision and also a letter will be sent within two (2) business days that explains our decision. If we approve your request, we will make sure that the non participating provider will be paid and you are not responsible for any costs except for any applicable co-pays. If we do not approve your request, our letter will explain how you can

appeal our decision. You will have sixty(60) days to appeal our decision. If we receive your appeal, we will send an acknowledgement letter within fifteen (15) days of receipt of your appeal and complete the appeal within thirty (30) calendar days. You will receive our decision in writing. If you wish to appeal, you may contact Member Services at 1-800-826-6240. If your PCP or Neighborhood Health Providers refers you to a provider outside our network, you are not responsible for any costs except the usual co-payments as described later in this handbook.

- If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a "**standing referral**"). If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
 - your specialist to act as your PCP; or
 - a referral to a specialty care center that deals with the treatment of your problem.
 - hospice services if you are terminally ill

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

GET THESE SERVICES - *WITHOUT A REFERRAL*

Women's Services:

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

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

Family Planning

- You can get the following family planning services: advice for birth control, prescription birth control, pregnancy tests, sterilization, or a medically necessary abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam or a pelvic exam. Prescriptions for birth control are covered by your Medicaid Fee-For-Service Benefit Card. See page 13 for co-payment information.
- You do not need a referral from your PCP to get these services. You can use your Plan ID card to see one of Neighborhood Health Providers' family planning providers and pharmacies. Check the Neighborhood Health Providers Provider Directory or call Member Services for help in finding a provider.

- If you have any questions or need information about these services, you can call Neighborhood Health Providers Member Services Department at 1-800-826-6240. You can call the New York State Growing Up Healthy Hotline at 1-800-522-5006 for information on where to get these services.

HIV Testing and Counseling

- You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP. Just make an appointment with a family planning provider.
- If you want HIV testing and counseling but not as part of a family planning service, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the New York State HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS.
- If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

Eye Care

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

You do not need a referral from your PCP for an eye exam or to get new glasses or to have your glasses repaired. You just choose one of our participating providers. But remember that you are limited to eye exams and new glasses once every two years. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you. You can call NHP's vision provider, Davis Vision at 1-800-999-5431 for questions regarding our vision network and benefits.

Behavioral Health Assessment

You may go for one (1) mental health and (1) chemical dependence (including alcohol and/or substance abuse) assessment without a referral in any 12-month period. You must use a NHP provider, but you do not need an approval from your PCP. If you need more visits, your PCP will help you get a referral. You can call NHP's Behavioral Health's vendor-Beacon Health Strategies at 1-866-969-2661 for questions or to request a referral.

Dental Care

Covered services generally include regular and routine dental services, supplies and devices required to alleviate health conditions. You may call NHP's dental services line at 1-888-307-6549 for questions about your dental benefits. Taking care of your teeth is an important part of your medical care, so remember to schedule your annual dental visit.

EMERGENCIES

You are always covered for emergencies.

An **emergency** means a medical or behavioral condition:

- that comes on suddenly, and
- has pain or other symptoms.

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

Examples of an emergency are:

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

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

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

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

- **If you are not sure, call your PCP or NEIGHBORHOOD HEALTH PROVIDERS.**

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

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

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

- Go to the nearest emergency room.

Remember

You do not need prior approval for emergency services.

- **Use the emergency room only if you have an EMERGENCY.**

- **The emergency room should NOT be used for problems like the flu, sore throats, or ear infections.**
- **If you have questions, call your PCP or NEIGHBORHOOD HEALTH PROVIDERS at 1-800-826-6240.**

URGENT CARE

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

- This could be an episode of persistent vomiting or diarrhea.
- 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. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-826-6240. Tell the person who answers what is happening. They will tell you what to do.

WE WANT TO KEEP YOU HEALTHY

Besides the regular check-ups you need, here are some other ways to keep you in good health:

- | | |
|---|---|
| • Health education classes | • Stop-smoking classes |
| • Grief / Loss support | • Breast feeding and baby care |
| • Stress management | • Weight control |
| • Prenatal care and nutrition | • Cholesterol control |
| • Diabetes counseling and self management | • Asthma counseling and self management |

Call Member Services at 1-800-826-6240 to find out more and get a list of upcoming classes.

HANDBOOK – PART 2

YOUR BENEFITS AND PLAN PROCEDURES

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

Benefits

FHPlus covers a comprehensive set of health care services or benefits. Neighborhood Health Providers will provide or arrange for all of the covered services. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific “self referral” services, as mentioned in Part 1.

Co-Payments

FHPlus members are required to make co-payments when receiving certain medical care and services. Some people are exempt and do not have to make these payments. See the following list of services that require co-payments and information about who is exempt. If you have questions, you may call Member Services at 1-800-826-6240 or the Department of Health’s Family Health Plus Information Line at 1-877-934-7587. If you have pharmacy benefit questions, please call the Medicaid Help Line at 1-800-541-2831.

Service	Co-Payment
• Brand Name Prescription Drugs	\$6 for each prescription and refill
• Generic Prescription Drugs	\$3 for each prescription and refill
• Clinic visit	\$5 per visit
• Physician visit	\$5 per visit
• Dental Service Visit	\$5 per visit up to a total of \$25 per year
• Lab tests	\$0.50 per test
• Radiology Services (like diagnostic x-rays, ultrasound, nuclear medicine and oncology services)	\$1 per radiology service
• Inpatient hospital stay	\$25 per stay
• Non-urgent emergency room visit	\$3 per visit
• Over-the counter medications (only for smoking cessation and diabetes)	\$0.50 per medication
• Medical supplies (only for diabetes and enteral formulae)	\$1 per supply

Co-payments do not apply to the following services:

- Emergency services
- Family planning services and supplies

- Mental health clinics
- Chemical dependence clinics
- Mental illness drugs
- Tuberculosis drugs
- Prescription drugs for a resident of an Adult Care Facility

You do not have to pay the co-payments if you are:

- Under age 21
- Pregnant
- A permanent resident of a nursing home
- A resident of community based residential facility licensed by the Office of Mental Health or the Office of Mental Retardation and Developmental Disability
- **Not able to pay the co-payment at any time and you tell the provider that you are unable to pay.**

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

SERVICES COVERED BY OUR PLAN

You must get these services from the providers who are in our plan. All services must be medically necessary and provided or referred by your PCP (primary care provider).

Regular Medical Care

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

Preventive Care

- regular check-ups
- tests and procedures ordered by your PCP or specialist
- smoking cessation counseling for pregnant women

Maternity Care

Women in FHPlus who become pregnant will qualify for Medicaid because the financial requirements are different and the family size is changed. If you become pregnant while you are enrolled in FHPlus, you have a choice to make. You may want to change coverage from FHPlus to Medicaid. Medicaid covers more services than FHPlus, which you may or may not need, depending on your medical needs. However, you may need to see a different doctor if you change from FHPlus to Medicaid. You should discuss this choice with your doctor and the local

Department of Social Services office or HRA so that you can make the decision that best meets your needs.

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

If you stay in FHPlus, we will cover:

- pregnancy care
- doctors/midwife and hospital services
- post-partum care

Home Health Care

Neighborhood Health Providers can arrange for some home health care visits (up to 40 per year), but this is generally only done to avoid your having to stay in a hospital. Your doctor must agree that your medical needs can be met at home with this help. Here are some times when this would be covered:

- if you stay in the hospital less than 48 hours after giving birth
- if you stay in the hospital less than 96 hours after a Cesarean birth
- other visits as needed and ordered by your PCP/specialist

Vision Care

FHPlus covers emergency vision care and the following preventive and routine vision care provided once in any twenty four month period:

- one eye exam;
- either one pair of prescription eyeglass lenses and a frame, or prescription contact lenses where medically necessary; and
- one pair of medically necessary occupational eyeglasses. Occupational eyeglasses are special glasses that help you perform your job duties.

Dental Care

- Covered services generally include regular and routine dental services, supplies and devices required to alleviate health conditions.
- Members are assigned a primary dentist.
You may call NHP's dental services line at 1-888-307-6549 to change your primary care dentist.

Hospital Care

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

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the emergency room, in an inpatient hospital room, or in another setting. These are called Post Stabilization Services.
- For more about emergency services, see page 11 for further information.

Behavioral Health Services

Neighborhood Health Providers will cover up to 60 outpatient visits and 30 inpatient visits a year for behavioral health services. Behavioral Health Services include Chemical Dependence Services (including alcohol and substance abuse services) and Mental Health Treatment Services.

Detoxification Services (Inpatient Detoxification and Inpatient or Outpatient Withdrawal Services) do not count towards the limits mentioned above.

You can call our behavioral health vendor, Beacon Health Strategies at 1-866-969-2661 if you have any questions about this benefit.

Specialty Care

Includes the services of other practitioners, including

- occupational, physical and speech therapists needed on a short-term basis
- midwives
- audiologists

Other Covered Services

- Emergency transportation service
- Durable Medical Equipment (DME)
- Hospice Services
- Hearing Aids/Supplies

- Prosthetics/Orthotics
- Court Ordered services, if covered by the plan.
- 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.

Pharmacy Benefit

Family Health Plus members must use their Medicaid Benefit ID card to get prescription drugs, smoking cessation products, hearing aid products, diabetic supplies, enteral formulae and certain over-the-counter medications covered on the Medicaid Preferred Drug List. You must use a pharmacy that accepts Medicaid.

Co-payments apply for most medications. Some members are not required to pay these co-payments. For a list of the co-payments, refer to the Co-Payment chart found on page 13.

Certain medications may require that your doctor get prior authorization from Medicaid before writing your prescription. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

SERVICES *NOT* COVERED

These services are **not** available from Neighborhood Health Providers. If you get any of these services, you may have to pay the bill.

- Cosmetic surgery if not medically needed
- Routine foot care (for those 21 years and older)
- Orthopedic shoes and shoe inserts
- Personal and comfort items
- Infertility treatments
- Services from a provider that is not part of Neighborhood Health Providers (unless Neighborhood Health Providers or your PCP sends you to that provider).
- Those services not given an approval in advance by your PCP.
- Personal care services
- Private duty nursing services
- Medical supplies (like bandages), non-prescription drugs (OTCs like aspirin)
- Nursing home stays that are permanent
- Non-emergency transportation (unless you are 19 or 20 and in the C/THP program)

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

If you have any questions, call Member Services at 1-800-826-6240.

SERVICE AUTHORIZATION AND ACTIONS

Prior Authorization:

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

- All elective or schedule admissions
- MRIs (Magnetic Resonance Imaging), Nuclear Medicine Imaging (PET/SPECT), Echos and Sonograms (excluding Maternity)
- Durable medical equipment (DME) greater than \$250
- Home Health Care
- Gastric By-pass Surgery
- Cardiac Rehabilitation
- Orthotics and Prosthetics greater than \$250
- Growth Hormones and other selective injectable medications
- Transportation: non emergent only
- All out of network ambulatory services
- All out of network specialist referrals
- Any services provided by an out of network provider

You or your doctor can call the Care Management Department at 1-800-765-3805 or you may call our toll-free Member Services number at 1-800-826-6240 or send your request in writing to Neighborhood Health Providers, Care Management Department at 4944 Parkway Plaza Blvd, Suite 110, Charlotte, NC 28217.

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

What happens after we get your service authorization request:

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

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

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

Timeframes for prior authorization requests:

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

Timeframes for concurrent review requests:

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 3 work days after we received your request. We will tell you by the third work day if we need more information.

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling Member Services number at 1-800-826-6240 or send your request in writing to Neighborhood Health Providers, Care Management Department at 4944 Parkway Plaza Blvd, Suite 110, Charlotte, NC 28217.

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

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

Other Decisions About Your Care:

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

Timeframes for notice of other actions:

- In most cases, if we make a decision to reduce, suspend or terminate a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by FHPlus even if we later deny payment to the provider.

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at 1-800-826-6240 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient's PCP. The fee stays the same whether the patient needs one visit or many - or even none at all. This is called capitation.

- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an incentive fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by Neighborhood Health Providers.
- Providers may also be paid by fee-for-service. This means they get a Plan-agreed-upon fee for each service they provide.

YOU CAN HELP WITH PLAN POLICIES

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

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at 1-800-826-6240:

- A list of names, addresses, and titles of Neighborhood Health Providers' 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 State Insurance Department about consumer complaints about Neighborhood Health Providers.
- How we keep your medical records and member information private.
- In writing, we will tell you how our plan 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 our plan.
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of our plan.
- If you ask, we will tell you:
 - whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so,
 - information on the type of incentive arrangements used; and
 - whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

KEEP US INFORMED

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

- you change your name, address or telephone number

- you have a change in circumstances that will affect your eligibility for FHPlus
- you are pregnant
- you give birth
- you become covered under another health insurance

OPTIONS

1. If YOU Want to Leave Neighborhood Health Providers

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

These are examples of “**good cause**”:

- Our health plan cannot provide a suitable primary care provider for you within acceptable travel times (if providers are routinely within 30 minutes or 30 miles from where you live).
- Our health plan does not meet New York State requirements and members are harmed because of it.
- You move out of our service area.
- You, the plan, and the LDSS all agree that disenrollment is best for you.
- We do not offer a FHPlus covered service that you can get from another FHPlus plan.
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk.
- We have not been able to provide services to you as we are required to under our contract with the State.

If you live in Brooklyn, Bronx, Manhattan, Queens or Staten Island Counties, call New York Medicaid CHOICE at 1-800-505-5678 and tell them you want to transfer to another Family Health Plus plan. You can transfer over the phone or ask for a Transfer Package. You will get a notice that the change will take place by a certain date. We will provide the care you need until then.

2. You Could Become Ineligible for Neighborhood Health Providers FHPlus Program

You may have to leave Neighborhood Health Providers if you:

- move out of the county or service area,

- have a change in income that makes you ineligible for FHPlus,
- join an HMO or other insurance plan through work,
- receive Medicare coverage,
- join a Long-term Home Health Care Program,
- are incarcerated, or
- you turn 65 years of age.

You are **"guaranteed" coverage** by Neighborhood Health Providers during the first six (6) months of your enrollment - even if you are no longer eligible for FHPlus. The reasons for your losing eligibility must not be related to death, moving out of state, or incarceration. During this time you can get the services that our plan covers. Guaranteed coverage does **not** apply if you **choose** to leave Neighborhood Health Providers.

3. We Can Ask You to Leave Neighborhood Health Providers

You can also lose your membership in Neighborhood Health Providers, if you often:

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

4. You may want to change from FHPlus to Medicaid with a "spend down"

FHPlus doesn't cover all the services that Medicaid does (like medical supplies), and some FHPlus services have limits that Medicaid doesn't (like physical therapy).

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

If your income is higher than that allowed for Medicaid, but you have medical bills that are greater than the amount your income is over the Medicaid level, those bills could help you qualify for Medicaid. This only applies to people who:

- are under age 21, or
- are disabled or blind, or
- have children under age 21, or
- are over age 65, or
- are pregnant (see below also).

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

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

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

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

ACTION APPEALS

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

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

Your provider can ask for reconsideration:

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

You can file an action appeal:

- If you are not satisfied with an action we took or what we decide about your service authorization request, you have ninety (90) days to request an appeal after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at 1-800-826-6240 if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone 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.

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

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

What happens after we get your appeal:

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

Timeframes for Action Appeals:

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

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

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

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

be done by calling the Care Management Department at 1-800-765-3805 or writing to NHP Care Management Department at 4944 Parkway Plaza Blvd, Suite 110, Charlotte, NC, 28217.

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

If your original denial was because we said the service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your care:

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

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

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

External Appeals

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

Before you appeal to the state:

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

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

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

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

To ask for an external appeal, fill out an application and send it to the State Insurance Department. You can call Member Services at 1-800-826-6240 if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-800-826-6240

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

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited external appeal**. The external appeal reviewer will decide an expedited appeal in three days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

Fair Hearings

In some cases you may ask for a fair hearing from New York State.

- 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 Neighborhood Health Providers.
- You are not happy with a decision that we made about medical care you were getting. You feel the decision limits your Family Health Plus benefits or that we did not make the decision in a reasonable amount of time.
- You are not happy about a decision we made that denied medical care you wanted. You feel the decision limits your Family Health Plus benefits.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Family Health Plus benefits. You must file a complaint and appeal with Neighborhood Health Providers. If Neighborhood Health Providers agrees with your doctor, you may ask for a state fair hearing.
- The decision you receive from the fair hearing officer will be final.

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

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

1. By phone, call toll-free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet, www.otda.state.ny.us/oah/forms.asp
4. By mail, Fair Hearings, New York State Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201

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

Complaint Process

Complaints:

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

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

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to: NYS Department of Health, Division of Managed Care, Bureau of Managed Care Certification and Surveillance, Room 1911 Corning Tower ESP, Albany, NY 12237. You may also contact your local Department of Social Services with your complaint at anytime. You may call the New York State Insurance Department at (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with the Plan:

To file by phone, call Member Services 1-800-826-6240 Twenty-four (24) hours, seven(7) days a week If you call us after 5pm, 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 and request a complaint form. It should be mailed to NHP Member Services, Attn: Complaint Department at P.O. Box 19769 Charlotte, North Carolina 28219-9769

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

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

After we review your complaint:

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

Complaint Appeals:

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of Neighborhood Health Providers, you have a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services you need from Neighborhood Health Providers.
- Be told by your PCP 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.
- 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 PCP. You can ask that your medical record be amended or corrected, if needed.

- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or your OK.
- Use Neighborhood Health Providers 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 State Fair Hearing system.
- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.
- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints

Your Responsibilities

As a member of Neighborhood Health Providers, you agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for true emergencies.
- Call your PCP when you need medical care, even if it is after hours.

ADVANCE DIRECTIVES

There may come a time **when you can't decide about your own health care**. By planning in advance, you can arrange now for your wishes to be carried out.

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

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

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

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

IMPORTANT PHONE NUMBERS

Your PCP:.....See your NHP ID Card

Neighborhood Health Providers

Member Services.....	1-800-826-6240
Member Services TTY/TDD.....	1-800-662-1220
Care Management Department.....	1-800-765-3805
Vision Services.....	1-800-999-5431
Mental Health and Substance Abuse.....	1-866-969-2661
Dental Services.....	1-888-307-6549
New York State Department of Health (Complaints).....	1-800-206-8125
New York Medicaid CHOICE.....	1-800-505-5678

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

NEIGHBORHOOD HEALTH PROVIDERS NOTICE OF PRIVACY PRACTICES

In order to provide you with the benefits to which you are entitled, Neighborhood Health Providers (NHP) must collect, create and maintain health information about you. We respect the confidentiality of your health information and we will protect your information in a responsible and professional manner. NHP is required by law to maintain the privacy of this information. This Notice of Privacy Practices describes how we may use and disclose your health information. It also informs you of your rights regarding this information and how you can exercise those rights. NHP is required by law to provide you with this Notice and we will comply with its terms during the period when it is effective.

How we may use and disclose health information about you

The following is a list of the ways in which NHP may use and disclose your health information. We will use and disclose your health information only for one of the purposes on this list. In certain cases we provide examples of the types of uses or disclosures that fall within a particular category. These examples are intended to help you understand what these categories mean; they do not cover every type of use or disclosure within each category. Please note that, when making these disclosures, NHP must follow federal, state, and local laws that provide special protections for health information relating to certain alcohol and drug abuse treatment.

1. Uses and Disclosures for Payment and Health Care Operations. After NHP, or one of the government programs in which we participate, has obtained your general consent to use and disclose your health information to administer your benefits and for other purposes permitted by state or federal law, we may use and disclose your health information for the following purposes:

a. *Treatment.* We may use and disclose health information about you to facilitate treatment by health care providers. For example, if one of our participating health care providers is treating you, we may disclose to this provider health information relating to other health care services you have received that may be relevant to the provider's treatment.

b. *Payment.* We may use and disclose health information about you for our payment activities. Our payment activities include collecting premiums, determining your eligibility for benefits, reimbursing health care providers that treat you and obtaining payment from other insurers that may be responsible for providing coverage to you. For example, if a health care provider submits a bill to us for services you received, we may use health information about you to determine whether these services are covered under your benefit plan and the appropriate amount of payment to which the provider may be entitled.

c. *Health Care Operations.* We may use and disclose health information about you to carry out health care operations, which includes quality improvement activities, evaluating our own performance and resolving any complaints or grievances you may have. For example, we may collect and review records maintained by doctors and hospitals that have treated you to see whether they have provided you with preventive treatment and other important health services that are recommended by medical authorities.

d. *Appointment Reminders.* We may use and disclose your health information to remind you about appointments you have made to receive health care services or to encourage you to make such appointments.

e. *Treatment Alternatives.* We may use and disclose your health information to tell you about treatment alternatives or other health-related benefits and services that may be of interest to you.

2. Uses and Disclosures Without Your Consent or Authorization. NHP may use and disclose your health information without your specific written authorization for the following purposes:

a. *As required by law.* We may use and disclose your health information as required by state, federal or local law.

b. *For public health activities.* We may disclose your health information to public health authorities or other agencies and organizations conducting public health activities, such as preventing or controlling disease, injury or disability and reporting births, deaths, child abuse or neglect, domestic violence, potential problems with products regulated by the Food and Drug Administration or communicable diseases.

c. *For judicial and administrative proceedings.* We may disclose your health information in the course of any judicial or administrative proceeding in response to an appropriate order of a court or administrative body.

d. *For law enforcement purposes.* We may disclose your health information to a law enforcement official for a legitimate law enforcement purpose such as: identifying or locating a suspect, fugitive or missing person.

e. *For health oversight activities.* We may disclose your health information to health oversight agencies for the following oversight activities authorized by law: (1) audits, investigations, inspections; (2) licensing or disciplining actions; (3) civil, administrative or criminal proceedings, or other activities necessary for appropriate oversight of the health care system; (4) government benefit programs; and (5) compliance with government regulatory programs and civil rights laws.

f. *To avert a serious threat to health or safety.* We may use or disclose your health information to prevent or lessen a serious and immediate threat to your health or safety or to the health or safety of another person or the general public. We will disclose your health information for this purpose only to someone who may be able to prevent or lessen this type of threat.

g. *For specialized government functions.* If you are a member of the armed forces, we may disclose your health information as required by military authorities. We also may disclose your health information to authorized federal officials for national security activities. In addition, we may disclose inmates' health information to correctional institutions in limited circumstances.

h. *For workers' compensation.* We may use or disclose your health information to comply with workers' compensation laws.

i. *To individuals involved in your care.* We may disclose your health information to person who represents you if you tell us to do so.

3. Your authorization is required for other uses and disclosures. NHP will not use or disclose your health information for any purpose **not specified** in this Notice of Privacy Practices **unless we obtain your express written authorization.** If you give us your authorization, **you may revoke it at any time**, in which case we will no longer use or disclose your health information for the purpose you authorized, except to the extent we have relied on your authorization in providing benefits. While you are required to sign a consent form in order to receive benefits from NHP, we may not refuse to enroll or continue to provide benefits to you if you decide not to sign an authorization form.

Your Rights Regarding Your Health Information

You have the following rights regarding your health information:

1. **Right to See and Copy.** You have the right to see or get a copy of health information about you that we maintain and that we may use in making decisions about your benefits. In certain situations, we may deny your request. We may charge you a reasonable fee for copies to cover our costs. You may ask to inspect or obtain copies of your information by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769.

2. **Right to Request Amendments.** You have the right to request changes to any health information we maintain about you if you state a reason why this information is incorrect or incomplete. If we do not believe the changes you requested are appropriate, we will notify you in writing how you can have your objection to our decision included in our records. You may request changes to your health information by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

3. **Right to an Accounting of Disclosures.** You have the right to receive a list of disclosures of your health information that have been made by NHP. The list will not include disclosures made for certain types of purposes, such as disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period for which you want this list, which can be no longer than six years and may not include dates prior to April 14, 2003. The first time you ask for a list of disclosures in any 12-month period, we will provide it for free. If you request additional lists during a 12-month period, we may charge you a fee to cover our costs in providing the additional lists. You may request a list of disclosures by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

4. **Right to Request Restrictions.** You have the right to request restrictions on the ways in which we use and disclose your health information for treatment, payment and health care operations, or individuals who are involved in your care. While we may honor your request, we are not required to agree to these restrictions. You may request a restriction on the use or disclosure of your health information by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

5. **Right to Request Confidential Communications.** You have the right to ask us to send health information to you in a different way or at a different location if you believe that you may be endangered by our ordinary form of communication. For example, if you are afraid that someone living with you may open mail we send you and harm you as a result, you can ask us to send your mail to a relative's or employer's address. We will require that you make your request in writing. We will accommodate all reasonable requests. You may ask us to send health information to you in a different way or at a different location by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

6. **Right to Paper Copy of Notice.** You have the right to receive a paper copy of this Notice of Privacy Practices at any time by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. Please include the date of the request, your signature or the signature of your representative and the reason for the request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with NHP by writing to Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769. NHP will not take any action against you for filing a complaint. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Changes to this Notice

NHP may change the terms of this Notice of Privacy Practices at any time. If we change the terms of this Notice, the new terms will apply to all of your health information, whether created or received by us before or after the date on which the Notice is changed. We will notify you of changes to this Notice by mailing you a copy of the new Notice within 60 days of the date on which it becomes effective.

Additional Information

If you have any questions or would like additional information about this Notice or NHP's privacy practices, please contact Member Services, P.O. Box 19769 Charlotte, NC, 28219-9769.

Effective Date

This Notice of Privacy Practices is effective as of May 15, 2009.

