



# MEMBER HANDBOOK

Western New York  
Medicaid

[www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans)



BLUECROSS BLUESHIELD OF WESTERN NEW YORK  
MEDICAID MANAGED CARE  
MEMBER HANDBOOK  
Revised June 2018

**SERVICE AUTHORIZATION AND APPEAL CHANGES EFFECTIVE 5/1/18**

Western New York  
[www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans)



**“If you do not speak English**, call us at 1-866-231-0847 (TTY 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.”

**Spanish: Si usted no habla inglés**, llámenos al 1-866-231-0847 (TTY 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

**French: Si vous ne parlez pas anglais**, appelez-nous au 1-866-231-0847 (TTY 711). Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

**Haitian Creole: Si ou pa pale lang Anglè**, rele nou nan 1-866-231-0847 (TTY 711). Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.

**Italian: Se non parli inglese** chiamaci al 1-866-231-0847 (TTY 711). Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua.

**Russian: Если вы не разговариваете по-английски**, позвоните нам по номеру 1-866-231-0847 (TTY 711) У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке.

**Chinese (PRC) 如果您不会讲英语**，请拨打会员服务号码 1-866-231-0847 (TTY 711) 与我们联系。我们提供各种口译服务，可以用您的语言帮助回答您的问题。此外，我们还可以帮您寻找能够用您的语言与您交流的医疗护理提供方。

**Chinese (Taiwan) 如果您無法使用英語交談**，請以下列電話號碼與我們聯繫：  
1-866-231-0847 (TTY 711)。我們會使用口譯服務以您的語言來協助回答您的問題。我們也可以協助您找到能夠使用您母語溝通的健康照護提供者。

## IMPORTANT PHONE NUMBERS

Your PCP.....

\_\_\_\_\_  
(write number above)

BlueCross BlueShield of Western New York Member Services  
Member Services TTY/TDD  
24/7 NurseLine  
Quality Management (Complaints and Appeals)

1-866-231-0847  
711  
1-866-231-0847 (TTY 711)  
1-844-401-2292

Your nearest emergency room.....

\_\_\_\_\_  
(write number above)

New York State Department of Health (Complaints)

1-800-206-8125

County Department Social Services

Allegany County Department of Social Services	1-585-268-9300
Cattaraugus County Department of Social Services	1-716-373-8077
Chautauqua County Department of Social Services	1-877-653-0216
Erie County Department of Social Services	1-716-858-6105
Genesee County Department of Social Services	1-585-344-8502
Niagara County Department of Social Services	1-716-278-8400
Orleans County Department of Social Services	1-585-589-3209
Wyoming County Department of Social Services	1-585-786-8900
Medical Answering Services (MAS)	
Allegany	1-866-271-0564
Cattaraugus	1-866-371-4751
Chautauqua	1-855-733-9405
Erie	1-800-651-7040
Genesee	1-855-733-9404
Niagara	1-866-753-4430
Orleans	1-866-260-2305
Wyoming	1-855-733-9403

New York Medicaid Choice

1-800-505-5678

Local Pharmacy

\_\_\_\_\_  
(write number above)

Other Health Providers:

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(write number above)

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(write number above)

# HERE'S WHERE TO FIND INFORMATION YOU WANT

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# WELCOME TO THE BLUECROSS BLUESHIELD OF WESTERN NEW YORK MEDICAID MANAGED CARE PROGRAM

We're glad you're a BlueCross BlueShield of Western New York member. We want to make sure you get off to a good start. This handbook is your guide to all the health care services available to you. We will get in touch with you in the next two or three weeks to get to know you better. If you need to speak to us before then, call us at 1-866-231-0847 (TTY 711). You can ask questions, get help making appointments or learn how to choose a primary care provider (PCP). We are here to help however we can.

## How managed care plans work

### The plan, our doctors and you

Many consumers get their health benefits through managed care, which provides a central home for your care.

BlueCross BlueShield has a contract with the State Department of Health to meet the health care needs of people with Medicaid. 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 will find a list in our provider directory online at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans). You can also call us at 1-866-231-0847 (TTY 711) to request a provider directory.

When you join BlueCross BlueShield, one of our providers will take care of you. Most of the time, that person will be your primary care provider (PCP) or doctor. If you need to have a test, see a specialist or go to the hospital, your PCP will arrange it. In some cases, you can self-refer to certain doctors for some services. See the section **Get these services from BlueCross BlueShield without a referral** for details.

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

- Getting care from several doctors for the same problem
- Getting health care services 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. BlueCross BlueShield recognizes the trust needed between you, your family, your doctors and other care providers. We will never give out your medical or behavioral health history without your written approval. The only people who will have your clinical information will be:

- BlueCross BlueShield.
- Your primary care provider (PCP).
- Other providers who give you care.
- Your authorized representative.

If you have a PCP or health care manager, they will always discuss referrals to other providers with you in advance. BlueCross BlueShield staff has 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 BlueCross BlueShield. 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 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 visit the member website, [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans), for an electronic copy. Or you can call Member Services at 1-866-231-0847 (TTY 711). You can also call the managed care staff at your local Department of Social Services.

Allegany Department of Social Services	1-585-268-9300
Cattaraugus County Department of Social Services	1-716-373-8077
Chautauqua County Department of Social Services	1-877-653-0216
Erie County Department of Social Services	1-716-858-6105
Genesee County Department of Social Services	1-585-344-8502
Niagara County Department of Social Services	1-716-278-8400
Orleans County Department of Social Services	1-585-589-3209
Wyoming County Department of Social Services	1-585-786-8900

If you live in Erie County, you can also call the New York Medicaid Choice HelpLine at 1-800-505-5678.

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## Help from Member Services

There is someone to help you at Member Services Monday through Friday from 8:30 a.m. to 6 p.m. Eastern time. Call 1-866-231-0847 (TTY 711). If you need help or health care advice outside of these times, call our 24/7 NurseLine at 1-866-231-0847 (TTY 711). Follow the phone options to speak with a nurse 24 hours a day, 7 days a week.

You can call Member Services to get help anytime you have a question. You may call us or visit the member website at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans) to:

- Choose or change your primary care provider (PCP).
- Ask about benefits and services.
- Get help with referrals.
- Replace a lost ID card.
- Report the birth of a new baby.
- 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 BlueCross BlueShield on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your Local Department of Social Services right away if you become pregnant and let us help you to choose a doctor for your **newborn baby** before he or she is born.

We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of these member advisory meetings, call us to find a time and place that works 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 certain doctor'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 is getting care in your home now**, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

### **Your health plan ID card**

After you enroll, we will send you a welcome letter with a member ID card. Your BlueCross BlueShield of Western New York ID card should arrive within 14 days after your enrollment date. Your card has your primary care provider's name and phone number on it. It will also have your client identification number (CIN). If anything is wrong on your BlueCross BlueShield ID card, call us right away. Your ID card does not show that you have Medicaid or that BlueCross BlueShield 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 (on the first page of this handbook) is proof that you're a member. You should keep your Medicaid benefit card. You will need the card to get services BlueCross BlueShield does not cover.

## PART I - FIRST THINGS YOU SHOULD KNOW

### How to choose your primary care provider (PCP)

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

Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. There are several different kinds of doctors, like:

- Pediatricians, who treat children.
- Family practice doctors, who treat the whole family.
- Internal medicine doctors, who treat adults.

You can get help choosing a PCP or see if you already have one by visiting the member website at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans) or calling Member Services at 1-866-231-0847 (TTY 711).

You can view our provider directory online at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans). This is a list of all the doctors, clinics, hospitals, labs and others who work with BlueCross BlueShield of Western New York. It lists the addresses, phone numbers 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 they are taking new patients at the time you choose a PCP.

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. Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed and regular care during pregnancy.

We also contract with 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 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 provider at one of the FQHCs that we work with, listed below. Just call Member Services at 1-866-231-0847 (TTY 711) for help.

## **BlueCross BlueShield Federally Qualified Health Centers**

Community Health Center of Buffalo, Inc.

462 Grider St.

Buffalo, NY 14215

1-716-898-4449

Northwest Buffalo Community Health Care Center

155 Lawn Ave.

Buffalo, NY 14207

1-716-875-2904

Oak Orchard Community Health Center

301 West Ave.

Albion, NY 14411

1-585-589-5613

Seneca Nation of Indians Cattaraugus Indian Reservation

36 Thomas Indian School Drive

Irving, NY 14081

1-716-532-5582

Seneca Nation Health Department

P.O. Box 500

Salamanca, NY 14779

1-716-945-5894

Southern Tier Community Health Care Network

d.b.a. Universal Primary Care

500 Main St.

Olean, NY 14760

1-716-375-7500

Tri County Medicine

12 N. Church St.

Canaseraga, NY 14822

1-585-243-1700

In almost all cases, your doctors will be BlueCross BlueShield providers. There are four instances when you can still **see another doctor that you had before you joined BlueCross BlueShield**. In these cases, your doctor must agree to work with BlueCross BlueShield. You can continue to see your doctor if:

- You are more than three months pregnant when you join BlueCross BlueShield and you're getting prenatal care. In that case, you can keep your provider until after your delivery through postpartum care.
- At the time you join BlueCross BlueShield, 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.
- At the time you join BlueCross BlueShield, you're being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to two years.
- At the time you join BlueCross BlueShield, 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. BlueCross BlueShield 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**. You must call Member Services at 1-866-231-0847 (TTY 711) and ask for your specialist to be your PCP. You will need to give us:

- Your name and demographic information.
- Your medical information. This includes diagnoses, medical history, medications and equipment you've used and any procedural needs.
- Your history with the treating physician. This includes the number of times you've seen your PCP, the names of any physicians who are treating you and the dates of the visits.

We will reach out to your PCP or specialist if we need more information.

The Medical Director, specialist and PCP must consult and agree with the need to have your specialist act as your PCP.

We'll let you know in writing when we make a decision. If you're unhappy with our decision, you'll have the right to file an appeal. We'll tell you how to do so in the letter telling you our decision.

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 BlueCross BlueShield, 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're more than three months pregnant or if you're receiving ongoing treatment for a condition. If you're pregnant, you may continue to see your doctor for up to 60 days after delivery. If you're 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 us during this time.

If any of these conditions apply to you, check with your PCP or call Member Services at 1-866-231-0847 (TTY 711).

## **How to get regular health care**

Regular health care means exams, routine checkups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see 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
- Deal with a danger to your life
- Deal with a problem that could cause illness
- 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 him or her. 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. In most cases, your first visit should be within three months of your joining the plan. If you can, prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, any medications you are taking and any questions you have.

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

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

- Adult baseline and routine physicals: within 12 weeks

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- Urgent care: within 24 hours
- Nonurgent sick visits: within three days
- Routine, preventive care: within four weeks
- First prenatal visit: within three weeks during first trimester (two weeks during second, one week during third)
- First newborn visit: within two weeks of hospital discharge
- First family planning visit: within two weeks
- Follow-up visit after mental health/substance abuse ER or inpatient visit: five days
- Nonurgent mental health or substance abuse visit: two weeks

## **How to get specialty care and referrals**

If you need care your PCP cannot give you, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are BlueCross BlueShield providers. Talk with your PCP to make 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 BlueCross BlueShield of Western New York to approve before you can get them. Your PCP will be able to tell you what they are.

If you're having trouble getting a referral you think you need, contact Member Services at 1-866-231-0847 (TTY 711).

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 BlueCross BlueShield 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 copays as described in this handbook.

Your PCP can obtain a preauthorization for services with out-of-network providers by calling 1-866-231-0847 (TTY 711). Time frames for review can be found in the **Service authorizations** section of this handbook.

Sometimes we may not approve an out-of-network referral because we have a provider in BlueCross BlueShield who 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 the section **Plan Appeals** to find out how.

Sometimes, we may not approve an out-of-network referral for a specific treatment. This is because you asked for care that isn't very different from what you can get from a BlueCross BlueShield 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 section **Plan Appeals** to find out how.

If your doctor does not send this information, we will still review your action appeal. However, you may not be eligible for an external appeal. See the section **External Appeals** for more information.

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.

You can also call Member Services at 1-866-231-0847 (TTY 711) for help in getting access to a specialty care center.

### **Get these services from BlueCross BlueShield without a referral**

You do not need a referral from your BlueCross BlueShield of Western New York primary care provider (PCP) for all the services mentioned in this section. This means you're free to get these services without any special approvals.

#### **Women's health care**

You don't need a referral from your PCP to see a plan OB/GYN provider if you:

- Are pregnant
- Need OB/GYN services
- Need family planning services
- Want to see a midwife
- Need to have a breast or pelvic exam

#### **Family planning**

You can get these family planning services:

- Advice about birth control
- Birth control prescriptions
- Male and female condoms
- Pregnancy tests

- Sterilization
- 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 can choose where to get these services. You can use your BlueCross BlueShield member ID card to see one of our family planning providers. Check our provider directory or call Member Services at 1-866-231-0847 (TTY 711) for help finding a doctor.

You can also use your Medicaid card if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services (1-866-231-0847 (TTY 711)) for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

### **HIV and STI screening**

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

You can get an HIV or STI test anytime you have an office or clinic visit or have family planning services. You do not need a referral from your primary care provider (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.

Or, if you'd rather not see one of our BlueCross BlueShield doctors, you can use your Medicaid card to see a family planning provider outside BlueCross BlueShield. For help in finding either a plan provider or a Medicaid provider for family planning services, call Member Services at 1-866-231-0847 (TTY 711).

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 necessary. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You just choose one of our participating providers.

New eyeglasses, with Medicaid approved frames, are usually provided once every 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 drug or alcohol abuse services that you may need. You or your provider can call Member Services anytime for help at 1-866-231-0847 (TTY 711).

If at any time you think you need help with mental health or substance use, you can see any participating behavioral health provider that accepts BlueCross BlueShield 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're pregnant and think you need help with depression, you can get a screening to see what services you may need. You do not need a referral from your PCP. You can get a screening for depression during pregnancy and for up to a year after your delivery.

### **Emergencies**

You are always covered for emergencies. An emergency means a medical or behavioral condition:

- That comes on all of a sudden.
- Has pain or other symptoms.

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

Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop or a bad burn
- Broken bones
- Trouble breathing, convulsions, or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- A drug overdose

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

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

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

If you believe you have an emergency, call 911 or go to the emergency room. You don't need your plan or your PCP's approval before getting emergency care, and you're not required to use our hospitals or doctors.

**If you're not sure, call your PCP or BlueCross BlueShield**

Tell the person you speak with what is happening. Your PCP or Member Services representative will tell you one of these things:

- What to do at home.
- To come to the PCP's office.
- 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 BlueCross BlueShield at 1-866-231-0847 (TTY 711).**

**Urgent care**

You may have an injury or an illness that is not an emergency but still needs prompt care. Some examples of urgent care situations are:

- A child with an earache who wakes up in the middle of the night and won't stop crying.
- The flu.
- If you need stitches.
- 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 1-866-231-0847 (TTY 711). Tell the person who answers what is happening. They will tell you what to do.

### **Care outside of the United States**

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

### **We want to keep you healthy**

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

- Classes for you and your family
- Classes for help quitting smoking
- Prenatal care and nutrition
- Grief/Loss support
- Breastfeeding 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 and protecting yourself from STIs
- Domestic violence services

Visit our website at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans) or call Member Services at 1-866-231-0847 (TTY 711) to find out more.

### **Health home care management**

BlueCross BlueShield of Western New York 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 primary care provider (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.

- Help manage ongoing medical issues like diabetes, asthma and high blood pressure.

To learn more about health home, call Member Services at 1-866-231-0847 (TTY 711).

## **New Baby, New Life<sup>SM</sup> program for pregnant women**

### **Special care for pregnant members**

New Baby, New Life<sup>SM</sup> is the BlueCross BlueShield program for all pregnant members. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist (OB/GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you have already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

Our program also helps pregnant members with complicated health care needs. Nurse case managers work closely with these members to provide:

- Education.
- Emotional support.
- Help in following their doctor's care plan.
- Information on services and resources in your community, such as transportation, Women, Infants, and Children program (WIC), home-visitor programs, breastfeeding and counseling.

Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and delivery of healthy babies.

### **Quality care for you and your baby**

At BlueCross BlueShield, we want to give you the very best care during your pregnancy. That's why we invite you to enroll in My Advocate<sup>TM</sup>, which is part of our New Baby, New Life<sup>SM</sup> program. My Advocate<sup>TM</sup> gives you the information and support you need to stay healthy during your pregnancy.

### **Get to know My Advocate<sup>TM</sup>**

My Advocate<sup>TM</sup> delivers maternal health education by phone, text messaging and smartphone app that is helpful and fun. You will get to know Mary Beth, the My Advocate<sup>TM</sup> automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.
- Communication with your case manager based on My Advocate<sup>TM</sup> messaging should questions or issues arise.
- An easy communication schedule.

This is provided at no cost to you.

With My Advocate<sup>TM</sup>, your information is kept secure and private. Each time Mary Beth calls, she'll ask you for your year of birth. Please don't hesitate to tell her. She needs the information to be sure she's talking to the right person.

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**Helping you and your baby stay healthy**

My Advocate™ calls give you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn and answer a question or two over the phone. If you tell us you have a problem, you'll get a call back from a case manager. My Advocate™ topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Dental care.
- Immunizations.
- Healthy living tips.

**When you become pregnant**

If you think you are pregnant:

- Call your PCP or OB/GYN doctor right away. You do not need a referral from your PCP to see an OB/GYN doctor.
- Call Member Services if you need help finding an OB/GYN in the BlueCross BlueShield network

When you find out you are pregnant, you must also call Member Services at 1-866-231-0847 (TTY 711).

We will send you a pregnancy education package. It will include:

- A congratulations letter.
- A self-care book with information about your pregnancy. You can also use this book to write down things that happen during your pregnancy.
- *A Labor, Delivery and Beyond* booklet with information on what to expect during your third trimester.
- A Healthy Rewards program brochure/handbook with information on how to redeem your rewards for prenatal care.
- A My Advocate™ flier that tells you about the program and how to enroll and get health information to your phone by automated voice, text message or smartphone app.
- *A Having a Healthy Baby* brochure with helpful resources.
- A Long Acting Reversible Contraception (LARC) flier with information on long acting reversible contraception.

While you are pregnant, you need to take good care of your health. You may be able to get healthy food from Women, Infants, and Children program (WIC). Member Services can give you the phone number for the WIC program close to you.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every four weeks for the first six months

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- Every two weeks for the seventh and eighth months
- Every week during the last month

Your PCP or OB/GYN may want you to visit more than this based on your health needs.

### **When you have a new baby**

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery
- 72 hours after a Cesarean section (C-section)

You may stay in the hospital less time if you PCP or OB/GYN and the baby's provider see that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby, you must:

- Call Member Services at 1-866-231-0847 (TTY 711) as soon as you can to notify BlueCross BlueShield that you had your baby. We will need details about your baby.
- Call your Local Department of Social Services for information about applying for Medicaid for your baby.

### **After you have your baby**

BlueCross BlueShield will send you postpartum education package after you have your baby. It will include:

- A congratulations letter.
- A *Nurture* booklet with information on caring for your newborn.
- A Healthy Rewards program brochure with information on how to redeem your rewards for postpartum care and well-baby/well child care.
- A postpartum depression brochure.
- A *Making a Family Life Plan* brochure.

If you enrolled in My Advocate™ and received educational calls during your pregnancy, you will now get calls on postpartum and well-child education up to 12 weeks after your delivery.

It's important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- The visit should be done between 21 and 56 days after you deliver.
- If you delivered by C-section, your PCP or OB/GYN may ask you to come back for a one or two week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 21 to 56 days after your delivery for your postpartum checkup.

## **Disease Management (DM) program**

BlueCross BlueShield of Western New York has a team of licensed nurses called case managers who help educate you about your condition and help you learn how to manage your care. Your PCP and our team of case managers will assist you with your health care needs. This is a voluntary program, and you can choose whether to participate or not. Case managers can also provide support over the phone for members with certain health conditions, such as:

- Diabetes
- HIV/AIDS
- Heart conditions like coronary artery disease, congestive heart failure and hypertension
- Lung conditions like asthma and chronic obstructive pulmonary disease (COPD)
- Behavioral health disorders, such as bipolar disorder, major depressive disorder, schizophrenia and substance use disorder

DM case managers work with you to create health goals and help you develop a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you create a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Gives health information that can help you make better choices.
- Assists you in coordinating care with your providers.

As a BlueCross BlueShield member enrolled in the DM program, you have certain rights and responsibilities.

You have the right to:

- Get details about us, including:
  - Programs and services we provide.
  - Our staff and their qualifications.
  - Any contractual relationships.
- Opt out of DM services.
- Know which case manager is handling your disease management services, as well as how to ask for a change.
- Get support from us to make health care choices with your providers.
- Be told about all disease management-related treatment options mentioned in clinical guidelines (even if a treatment is not covered), and to discuss options with treating providers.
- Have personal data and medical information kept private.
- Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
- Be treated politely and with respect by our staff.

- File complaints to BlueCross BlueShield and receive guidance on how to use the complaint process, including our standards of timeliness for responding to and resolving issues of quality and complaints.
- Receive information that is clear and easy to understand.

You are encouraged to:

- Follow the plan of care you and your case manager agree on.
- Provide us with information needed to carry out our services.
- Tell us and your provider if you decide to leave the program.

If you have questions or would like to know more about our disease management program, please call 1-888-830-4300 (TTY 711) Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time. Ask to speak with a case manager. You can also visit our website at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans).

## **PART II - YOUR BENEFITS AND PLAN PROCEDURES**

The rest of this handbook is for your information when you need it. It lists the services your health plan pays for as well as the services it will not pay for. If you have a complaint, this handbook tells you what to do. Keep this handbook handy for when you need it. It has lots of information you may find useful.

### **Evaluation of new technology**

BlueCross BlueShield of Western New York keeps up with changes in technology to see if they should be part of the benefits in our plan. Our medical director and the doctors in our plans review new medical advances or changes to technology in:

- Behavioral health.
- Devices.
- Medical treatment.
- Prescription drugs.

They also look at scientific findings to see if these new medical advances and treatments:

- Are considered safe and effective by the government.
- Give equal or better outcomes than the treatment or therapy that exists now.

### **Medical management**

Our plan bases its medical management decisions on the appropriateness of care and services. Decisions are based on your benefits. We do not reward or offer incentives to providers or staff members for issuing denials of coverage or service, nor do we offer financial incentives to encourage decisions that result in underutilization of care.

### **Benefits**

Medicaid managed care provides a number of services you get as well as those you get with regular Medicaid. BlueCross BlueShield of Western New York will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP, like:

- Emergency care
- Family planning services
- HIV testing and counseling
- Specific self-referral services, including those you can get from within BlueCross BlueShield and some that you can choose to go to any Medicaid service provider

Please call our Member Services department at 1-866-231-0847 (TTY 711) if you have any questions or need help with any of the services below.

## **Services covered by BlueCross BlueShield**

You must get these services from BlueCross BlueShield plan providers. All services must be medically or clinically necessary and provided or referred by your primary care provider (PCP). Please call Member Services at 1-866-231-0847 (TTY 711) 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 checkups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21 years
- Smoking cessation counseling
- Access to free needles and syringes
- HIV education and risk reduction

### **Maternity care**

- Pregnancy care
- Doctors/midwife and hospital services
- Newborn nursery care
- Screening for depression during pregnancy and up to a year after delivery

### **Home health care**

- Must be medically necessary and arranged by BlueCross BlueShield
- One medically necessary postpartum home health visit; more visits as medically necessary for high-risk women
- At least two visits to high-risk infants (newborns)
- Other home health care visits as needed and ordered by your PCP/specialist

### **Personal care/Home attendant/Consumer directed personal assistance services (CDPAS)**

- Must be medically needed and arranged by BlueCross BlueShield
- 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 BlueCross BlueShield at 1-866-231-0847 (TTY 711).

### **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 getting 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**

- 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 BlueCross BlueShield.
- 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 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 Member Services at 1-866-231-0847 (TTY 711).

### **Dental care**

BlueCross BlueShield believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with LIBERTY Dental Plan, an expert in providing high quality dental services

### **How to get dental services**

Once you enroll in BlueCross BlueShield, you will receive a letter from Member Services letting you know that it's time to choose your primary care dentist (PCD). You must choose a PCD within 30 days from the date of this letter, or we will choose one for you.

If you need to find a dentist or change your dentist, please call LIBERTY toll-free at 1-833-276-0846 or please call BlueCross BlueShield at 1-866-231-0847 (TTY 711). Customer Service representatives are there to help you. Many speak your language or have a contract with Language Line Services.

Show your member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card.

You can also go to a dental clinic that is run by an academic dental center without a referral. If you need help in locating a dental clinic you can contact LIBERTY at 1-833-276-0846.

### **Orthodontic care**

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

### **Vision care**

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

### **Pharmacy**

- Prescription drugs
- Over-the-counter (OTC) medicines
- Insulin and diabetic supplies
- Smoking cessation agents, including OTC products
- Emergency contraception (six per calendar year)
- Medical and surgical supplies

A pharmacy copay may be required for some people and for some medications and pharmacy items. There are no copays for these members or services:

- Members younger than 21 years old
- Pregnant members; they're exempt during pregnancy and for the two months after the month in which the pregnancy ends
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program

- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI)
- Family planning drugs and supplies like birth control pills and male or female condoms
- Generic copays (if plan is waiving copay)
- Drugs to treat mental illness (psychotropic) and tuberculosis
- Members belonging to a federally recognized Native American tribe

Prescription Item	Copay Amount	Copay Details
Brand-name prescription drugs	\$3.00/\$1.00	One copay charge for each new prescription and each refill
Generic prescription drugs	\$1.00	
Over the counter drugs (e.g., for smoking cessation and diabetes)	\$0.50	Per medication

There is a copay for each new prescription and each refill. If you have a copay, you are responsible for a maximum of \$200 per calendar year. If you transferred plans during the calendar year, keep your receipts as proof of your copays. Or you may request proof of paid copays from your pharmacy. You will need to give a copy to your new plan.

Certain medications may require your doctor get prior approval from us before writing your prescription. Your doctor can work with BlueCross BlueShield to make sure you get the medications you need. Learn more about prior authorization later in this handbook in the section **Service authorization**.

You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates with our plan or you can fill your prescriptions by using a mail-order pharmacy. For more information on your options, please call Member Services at 1-866-231-0847 (TTY 711).

### **Hospital care**

- Inpatient care
- Outpatient care
- Lab, X-ray or other tests

### **Emergency care**

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

**Specialty care**

Includes the services of other practitioners, like:

- Occupational, physical and speech therapists – limited to 20 visits per therapy per calendar year; this limit does not apply to children under age 21, if you have been deemed developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury
- Audiologists
- Midwives
- Cardiac rehabilitation
- Podiatrists if you're diabetic

**Residential health care facility care (Nursing Home)**

Covered nursing home services include:

- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy
- Speech-language pathology and other services

To get these nursing home services:

- The services must be ordered by your provider.
- The services must be authorized by BlueCross BlueShield.

**Rehabilitation**

BlueCross BlueShield covers short-term, or rehabilitation (also known as “rehab”) stays, in a skilled nursing home facility.

**Long term placement**

BlueCross BlueShield covers long-term placement in a nursing home facility for members 21 years of age or older.

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

When you are eligible for long-term placement, you may select one of the nursing homes in the BlueCross BlueShield plan that meets your needs.

If you want to live in a nursing home that is not in the BlueCross BlueShield plan, you must first 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.

**Determining your Medicaid eligibility for long-term nursing home services**

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You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or BlueCross BlueShield pay for long-term nursing home services. The LDSS will review your income and assets to determine if you're eligible 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.

### **Questions**

If you have any questions about these benefits, call BlueCross BlueShield Member Services at 1-866-231-0847 (TTY 711).

### **Additional resources**

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

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit [www.icannys.org](http://www.icannys.org).
- New York State Office for the Aging
- Health Insurance Information, Counseling and Assistance Program (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0511.
- NY CONNECTS is a link to long term service and supports. Call 1-800-342-9871 or visit [www.nyconnects.ny.gov](http://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](http://www.health.ny.gov/facilities/nursing/rights).

### **Behavioral health care**

Behavioral health care includes mental health and substance use disorder (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health or to help with alcohol or other substance use issues. For information about these services, please call Member Services at 1-866-231-0847 (TTY 711). Services offered include those described below.

### **Mental health care**

- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services if you are in a community home or in family-based treatment
- Continuing day treatment
- Personalized recovery oriented services
- Assertive community treatment services
- Individual and group counseling

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- Crisis intervention services

### **Substance use disorder services**

- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid, including methadone maintenance treatment
- Residential substance use disorder treatment
  - Outpatient alcohol and drug treatment services
- Detox services

### **Harm Reduction Services**

If you are in need of help related to substance use disorder, Harm Reduction Services can offer a complete patient-oriented approach to your health and well-being. BlueCross BlueShield 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 1-866-231-0847 (TTY 711).

### **Transportation**

To get nonemergency transportation services, you or your provider must call Medical Answering Services (MAS) at the number listed below for the county you live in. If possible, you or your provider should call MAS at least three days prior to 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. Nonemergency medical transportation includes: personal vehicle, bus, taxi, ambulette and public transportation.

Medical Answering Services: [www.medanswering.com](http://www.medanswering.com)

Allegany	1-866-271-0564	Genesee	1-855-733-9404
Cattaraugus	1-866-371-4751	Niagara	1-866-753-4430
Chautauqua	1-855-733-9405	Orleans	1-866-260-2305
Erie	1-800-651-7040	Wyoming	1-855-733-9403

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

### **Other covered services**

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- Durable medical equipment (DME)/Hearing aids/Prosthetics/Orthotics
- Court-ordered services
- Case management
- Help getting social support services
- FQHC
- Family planning
- Services of a podiatrist for children under 21 years old.

### **Benefits you can get from BlueCross BlueShield or with your Medicaid card**

For some services, you can choose where to get care. You can get these services by using your BlueCross BlueShield member ID card. You can also go to providers who will take your Medicaid Benefit card. You do not need a referral from your primary care provider (PCP) to get these services. Call us if you have questions at 1-866-231-0847 (TTY 711).

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

### **HIV and STI screening**

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

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

### **TB diagnosis and treatment**

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

### **Benefits using your Medicaid card only**

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

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 BlueCross BlueShield of Western New York  
 Member Services: 1-866-231-0847 (TTY 711)  
 Crisis Line: 1-866-231-0847 (TTY 711)  
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## **Developmental disabilities**

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

## **Services not covered**

These services are **not available** from BlueCross BlueShield of Western New York **or** Medicaid. If you get any of these services, you may have to pay the bill:

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

You may have to pay for any 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:

- Services not covered (listed above)
- Unauthorized services
- Services provided by providers not part of BlueCross BlueShield

## **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 us at 1-866-231-0847 (TTY 711) right away. BlueCross BlueShield can help you understand why you may have gotten a bill. If you're not responsible for payment, we will contact the provider and help fix the problem for you.

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

If you have any questions, call Member Services at 1-866-231-0847 (TTY 711).

## **Service authorization**

### **Prior authorization and time frames**

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

- Some ambulatory surgery
- Chemotherapy
- Dialysis
- Durable medical equipment
- Growth hormone evaluation and therapy
- Digital hearing aids
- Home care
- Hyperbaric oxygen therapy
- Inpatient services
- Lithotripsy
- Nonemergent fixed wing transportation
- Obstetrical services (except family planning services)
- Oxygen equipment/Respiratory therapy
- Prosthetics and orthotics
- Some drugs
- Transplant evaluation

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services, you need to ask your doctor to call the BlueCross BlueShield Medical Management department at 1-866-231-0847 (TTY 711).

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

### **What happens after we get your service authorization request**

The health plan has a review team to be sure you get the services we promise. We check that the service you are asking for is covered under your health plan. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically necessary 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 the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested.

You can request the specific medical standards, called **clinical review criteria**, we used to make

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's believed 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 expedite your review if:

- A delay will seriously risk your health, life or ability to function.
- Your provider says the review must be faster.
- You're asking for more of a service you currently receive.

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 the **Plan Appeals** and **Fair Hearing** sections of this handbook).

#### **Time frames for prior authorization requests**

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

**Fast track review:** We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

#### **Time frames for concurrent review requests**

**Standard review:** We will make a decision within one workday of when we have all the information we need. You will hear from us no later than 14 days after we received your request. We will tell you within 14 days if we need more information.

**Fast track review:** We will make a decision within one workday 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 one workday if we need more information.

#### **Special timeframes for other requests**

If you are in the hospital or have just left the hospital and you ask for home health care, we will make a decision within 72 hours of your request.

If you're getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your

request.

If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.

If you're asking for an outpatient prescription drug, we will make a decision within 24 hours of your request.

A step therapy protocol means you need to try another drug before we will approve the drug you're requesting. If you're asking for approval to override a step therapy protocol, we'll make a decision within 24 hours for outpatient prescription drugs. For other drugs, we will make a decision within 14 days of your request.

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

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

You, your provider or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-866-231-0847 (TTY 711) or writing to:

BlueCross BlueShield of Western New York  
P.O. Box 38  
Buffalo, NY 14240-0038

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

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

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

### **Other decisions about your care**

Sometimes we will do a concurrent review on the care you are receiving to see if you still need

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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.

### **Time frames 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're 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're checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving all the information we need for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

### **How our providers are paid**

You have the right to ask us whether we have any special financial arrangement with our providers and doctors that might affect your use of health care services. You can call Member Services at 1-866-231-0847 (TTY 711) if you have specific concerns. We also want you to know that most of our providers are paid in one or more of these ways:

- If our primary care provider (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 percent) 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 the plan.
- 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 you and all of our members. If you have ideas, tell us about them! Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 1-866-231-0847 (TTY 711) to find out how you can help.

### **Information from Member Services**

Here is information you can get by calling Member Services at 1-866-231-0847 (TTY 711):

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- A list of names, addresses and titles of BlueCross BlueShield's board of directors, officers, controlling parties, owners and partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about BlueCross BlueShield
- How we keep your medical records and member information private
- How we check on the quality of care to our members
- Which hospitals our health providers work with
- Information about how our company is organized and how it works

If you ask us in writing, we will tell you:

- The guidelines we use to review conditions or diseases that are covered by BlueCross BlueShield.
- The qualifications needed and how health care providers can apply to be part of BlueCross BlueShield.

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.

### **Keep us informed**

Call Member Services at 1-866-231-0847 (TTY 711) whenever these changes happen in your life:

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

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

### **Disenrollment and transfers**

#### **If you want to leave BlueCross BlueShield**

You can try us out for 90 days. You may leave BlueCross BlueShield 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 BlueCross BlueShield for nine more months, unless you have a good reason (good cause).

Some examples of good cause include:

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

**To change plans:**

- Call the Managed Care staff at your local Department of Social Services.
- If you live in Erie County, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans or disenroll.

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. BlueCross BlueShield 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. Just call your local Department of Social Services (see the section **Important Phone Numbers**) or New York Medicaid Choice at 1-800-505-5678.

**You could become ineligible for Medicaid managed care**

You or your child may have to leave BlueCross BlueShield if you or your child:

- Move out of the county or service area.
- Change to another managed care plan.
- Join an HMO or other insurance plan through work.
- Go to prison.
- Otherwise lose eligibility.

**Your child may have to leave BlueCross BlueShield or change plans if he or she:**

- Joins a physically handicapped children's program.
- Is placed in foster care by an agency that has a contract to provide that service for the local Department of Social Services.

- Is placed in foster care by the local Department of Social Services in an area that is not served by your child's current plan.

If you have to leave BlueCross BlueShield or become ineligible for Medicaid, all of your services may stop unexpectedly, as well as any care you receive at home. Call New York Medicaid Choice at 1-800-505-5769 right away if this happens.

### **We can ask you to leave BlueCross BlueShield**

You can also lose your BlueCross BlueShield membership, if you often:

- Refuse to work with your PCP in regard to your care.
- Don't keep appointments.
- Go to the emergency room for nonemergency care.
- Don't follow our 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.
- Act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

### **Plan Appeals**

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

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

### **Your provider can ask for reconsideration:**

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

### **You can file a Plan Appeal:**

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

You have 60 calendar days from the date of the initial adverse determination notice to ask for a Plan Appeal.

You can call Member Services at 1-866-231-0847 (TTY 711) if you need help filing a Plan Appeal or following the steps of the appeal process. We can help if you:

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- Have any special needs like hearing or vision impairment.
- If you need translation services.

You can ask for a Plan Appeal or 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.

**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 10 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.

We will not treat you any differently or act badly toward you because you file a Plan Appeal. When you ask for a Plan Appeal, you'll need to give us:

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

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the initial adverse determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-866-231-0847 (TTY 711).

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

Phone..... 1-866-231-0847 (TTY 711)

Fax..... 1-844-759-5954

Mail..... Member Complaints and Appeals

Department

BlueCross BlueShield of Western New York

P.O. Box 62429

Virginia Beach, VA 23466

In Person..... BlueCross BlueShield of Western New York

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257 W. Genesee St.  
Buffalo, NY 14202

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

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

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

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for. If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

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

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.

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- You can also provide information to be used in making the decision in person or in writing. Call the BlueCross BlueShield Appeals department at 1-866-231-0847 (TTY 711) 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 a person who did not make the 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.
  - Ask for an External Appeal (for some decisions). See the External Appeal section of this handbook.
  - File a complaint with the New York State Department of Health at 1-800-206-8125.

### **Time frames 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 two working days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.

- We will tell you within 72 hours if we need more information.
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
- We will tell you our decision by phone and send a written notice later.

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

- If you or your doctor asks to have your Plan Appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your Plan Appeal will be reviewed under the standard process; **or**
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided; **or**
- If your request was denied when you asked for home health care after you were in the hospital; **or**
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

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

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

You or your representative may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-844-401-2292 or writing:

Grievance and Appeals Department  
BlueCross BlueShield of Western New York  
P.O. Box 38  
Buffalo, NY 14240-0038

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

If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:  
1) Not medically necessary; 2) Experimental or investigational; 3) Not different from care you can get in the plan's network; or 4) Available from a participating provider who has correct training and experience to meet your needs, the original denial will be reversed. This means your service authorization request will be approved.

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

If we decide 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 **10 days** from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur, whichever is later.

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

#### **External appeals**

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

- 1) Not medically necessary;

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- 2) Experimental or investigational;
- 3) Not different from care you can get in the plan's network; or
- 4) Available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State for an independent **External Appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State.

The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an external appeal.

Before you ask for an external appeal:

- You must file a Plan Appeal and get the plan's Final Adverse Determination.
- 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.
- You and the plan may agree to skip the plan's appeals process and go directly to external appeal.
- You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

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

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 1-866-231-0847 (TTY 711) 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' website at [www.dfs.ny.gov](http://www.dfs.ny.gov)
- Contact the health plan at 1-866-231-0847 (TTY 711)

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

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health: or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

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Member Services: 1-866-231-0847 (TTY 711)  
Crisis Line: 1-866-231-0847 (TTY 711)  
WNY-MHB-0009-18

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 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, 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 BlueCross BlueShield.
- You are not happy with a decision that 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 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 BlueCross BlueShield. If BlueCross BlueShield agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that 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 BlueCross BlueShield. If BlueCross BlueShield agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  - Reduce, suspend or stop care you were getting; or
  - Deny care you wanted;
  - Deny payment for care you received; or
  - Did not let you dispute a copay 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 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:

- By phone: call toll free 1-800-342-3334
- By fax: 1-518-473-6735
- By Internet: [www.otda.state.ny.us/oah/forms.asp](http://www.otda.state.ny.us/oah/forms.asp)
- By mail:  
NYS Office of Temporary and Disability Assistance  
Office of Administrative Hearings  
Managed Care Hearing Unit  
P.O. Box 22023  
Albany, NY 12201-2023

When you ask for a Fair Hearing about a decision BlueCross BlueShield made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-866-231-0847 (TTY 711) to ask for it.

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

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## **Complaint process**

### **Complaints**

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

You can call Member Services at 1-866-231-0847 (TTY 711) if you need help filing a complaint or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

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

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

### **How to file a complaint with our plan**

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

To file by phone, call Member Services at 1-866-231-0847 (TTY 711) Monday through Friday from 8:30 a.m. to 6 p.m. Eastern time. 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 and request a complaint form. It should be mailed to:

Complaint Specialist  
Quality Management Department  
P.O. Box 62429

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Virginia Beach, VA 23466-2429

### **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 workdays. The letter will tell you:

- Who is working on your complaint
- How to contact this person
- If we need more information

You can give us more information to use when we review your complaint in person or in writing. Call BlueCross BlueShield at 1-866-231-0847 (TTY 711) if you're not sure what information to give us.

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

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

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

### **Complaint appeals**

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

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

- If you are not satisfied with what we decide, you have at least 60 workdays 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.

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

After we get your complaint appeal, we will send you a letter within 15 workdays. 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 workdays. If a delay would risk your health, you will get our decision in two workdays 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 BlueCross BlueShield, you have a right to:

- Be told about the health plan and its services, practitioners and providers.
- Be told about your rights and responsibilities and make suggestions about them.
- 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 BlueCross BlueShield.
- 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.
- Hear about all available treatment options no matter what your benefits cover or how much the options cost.
- 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, 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 BlueCross BlueShield 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 BlueCross BlueShield, you agree to:

- Give your PCP, the health plan and other providers correct information about your health.
- Work with your PCP to guard and improve your health and follow plans and instructions for care.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt so you can understand your health conditions and/or treatment options and work with your PCP to meet your goals.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.
- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for real emergencies.
- Call your PCP when you need medical care, even if it is after-hours.

### **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**

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

**Organ donor card**

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

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.**

**HIPAA Notice of Privacy Practices**

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

**Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.**

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

**When is it OK for us to use and share your PHI?**

We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them

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- To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans) for more information.
- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

**Other ways we can — or the law says we have to — use your PHI:**

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

**What are your rights?**

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some

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- other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
  - You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
  - If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

**What do we have to do?**

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

**Contacting you**

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

**What if you have questions?**

If you have questions about our privacy rules or want to use your rights, please call Member Services at 1-866-231-0847 (TTY 711).

**What if you have a complaint?**

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

**Write to or call the Department of Health and Human Services:**

Office for Civil Rights  
U.S. Department of Health and Human Services  
Jacob Javits Federal Building  
26 Federal Plaza, Suite 3312  
New York, NY 10278  
Phone: 1-800-368-1019  
TDD: 1-800-537-7697  
Fax: 212-264-3039

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at [www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans).

**Race, ethnicity and language**

We receive race, ethnicity and language information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Develop and send health education information
- Let doctors know about your language needs
- Provide translator services

We do **not** use this information to:

- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Disclose to unapproved users

**Your personal information**

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies

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- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

**[www.bcbswny.com/stateplans](http://www.bcbswny.com/stateplans)**

Amerigroup Partnership Plan, LLC provides management services for BlueCross BlueShield of Western New York's managed Medicaid. A division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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