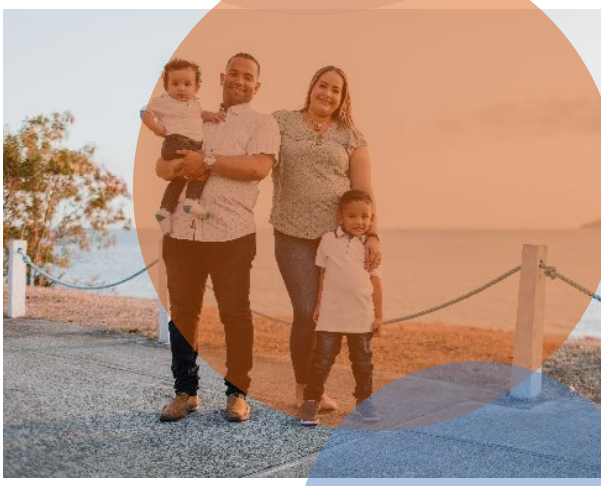
2019 Member Handbook



PHP
PARTNERS
HEALTH PLAN

PHP CARE PREFERRED

KEEP THIS HANDBOOK FOR YOUR RECORDS

If you do not speak English, call us at 1-855-747-5483. 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 1-855-747-5483. 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 1-855-747-5483. 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 1-855-747-5483. 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 1-855-747-5483. 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 1-855-747-5483. 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 1-855-747-5483 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 (Taiwain) 如果您無法使用英語交談，請以下列電話號碼與我們聯繫：1-855-747-5483。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。

HERE'S WHERE TO FIND INFORMATION YOU WANT

WELCOME TO PARTNERS HEALTH PLAN'S SPECIALIZED PHSP MEDICAID MANAGED CARE PROGRAM

We are glad that you chose Partners Health Plan's (PHP) specialized prepaid health services plan (PHSP), PHP Care Preferred. This Handbook will serve as your guide to the full range of health care services available to you through PHP. We want to be sure you get off to a good start as a new member. To get to know you better, we'll get in touch with you in the next week or two. At that time, you can ask us any questions you have or get help making appointments. However, if you need to speak with us sooner, just call us at 1-855-747-5483.

How Managed Care Plans Work

PHP, Our Providers, and You

Many people get their health benefits through managed care, which provides a central home for your care. If you were getting health services using your Medicaid card, now those services may be available through PHP. PHP has a contract with the State Department of Health to meet the health care needs of people with Medicaid, with a particular emphasis on people with intellectual and other developmental disabilities (I/DD). In turn, we choose a group of health care providers to help us meet your needs, including providers with proven expertise in providing supports and services for people with I/DD. These doctors and specialists, hospitals, labs, and other health care facilities make up our provider network. You will find a list of doctors, hospitals, and other health care facilities and professionals in our Provider Directory. If you do not have a Provider Directory, call 1-855-747-5483 to get a copy or visit our website at www.phpcares.org.

When you join PHP, one of our providers will take care of you. Most of the time that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

Most of our members will also be getting services from OPWDD or, if you are still in school, through the Department of Education. PHP works together with OPWDD and the Department of Education to help make sure your needs are met. PHP will help you with your medical needs such as going to the doctor or dentist, while OPWDD and/or the Department of Education will help you with other important things such as making sure you are safe and learning how to be the person you want to be. Working together, we will help you to live the life you choose.

Confidentiality

We respect your right to privacy. Partners Health Plan recognizes the trust needed between you, your family, your doctors and other care providers. Partners Health Plan will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be Partners Health Plan, your Primary Care Provider and other providers who give you care and your authorized representative. Referrals to such providers will always be discussed with you in advance

by your Primary Care Provider or your Health Home Care Manager, if you have one. Partners Health Plan 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 Partners Health Plan. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

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

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

If you live in Nassau, Suffolk, Rockland, Westchester, Manhattan, Queens, Brooklyn, Bronx, or Staten Island, you can also call the New York Medicaid Choice Help Line at 1-800-505-5678.

Help from Member Services

There is someone to help you at Member Services Monday through Friday from 8 a.m. to 6 p.m. except on state holidays. Call 1-855-747-5483. If you need help or health care advice outside of these times, call our 24/7 Nurse Hotline at 1-855-769-2507. 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 to choose or change your Primary Care Provider (or PCP for short), to ask about benefits and services, to get help with finding other doctors, to replace a lost ID card, to report the birth of a new baby, or ask about any change that might affect your benefits.

If you are or think you are pregnant, you should let us know as soon as possible so we can make sure you get the care you and your baby need. Your child will become part of PHP on the day he or she is born.

If You Do Not Speak English

If you do not speak English, we can help. We want you to understand how PHP works to help you no matter what language you speak. Just call us at 1-855-747-5483 and we will arrange to talk to you in your own language. We will also help you to find a PCP who can serve you in your own language.

If You Need Other Help

If you are blind, or have trouble hearing or understanding, call us. We can arrange to assist you at no charge to you or your family. We can also help you with finding a doctor with special equipment or skills. We can arrange services like:

- TTY machine (our TTY phone number is 711)
- Information in Large Print
- Help in making or getting to appointments
- Names and addresses of providers who specialize in assisting people like you

If You Have Multiple Health Issues

If you have multiple health issues, you may benefit from Health Home Care Management to help coordinate all of your health services.

- A Health Home Care Manager can:
- Work with your PCP and other providers to coordinate all of your health care
- Work with the people you trust, like family members or friends, to help you plan and get your care
- Help with appointments with your PCP and other providers
- Help manage ongoing medical issues like diabetes, asthma, and high blood pressure.

To learn more about Health Homes, call us at 1-855-747-5483.

Your PHP ID Card

After you enroll, we will send you a Welcome Letter. Your PHP ID card should arrive within 14 days after your enrollment date. Your card has your PCP's (primary care provider's) name and phone number on it. It will also have your Client Identification Number (CIN). Your ID card does not show that you have Medicaid or that PHP is a special type of health plan. Carry your ID card whenever you leave home and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should also keep your Medicaid benefit card to get services that PHP does not cover.

PART I: FIRST THINGS YOU SHOULD KNOW

What is a Primary Care Provider (PCP)?

A primary care provider, or PCP for short, serves as your "medical home," which is the place you go to get most of your health care. In this role, PCPs take care of your day-to-day health care needs such as:

- Performing examinations
- Ordering laboratory tests, x-rays, and other screenings
- Giving shots
- Treating routine health problems like a sore throat, bad cough, or a sprained ankle
- Telling you when something might be wrong with your health, explaining what you might do to get better, answering your questions, and treating you with courtesy and respect
- Referring you to other doctors for special problems
- Talking about your health to other people involved in your care
- Keeping your medical records up to date
- Being available whenever you need a doctor, day or night

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, you should do so right away. We will be happy to help you – just call Member Services at 1-855-747-5483. If you do not choose a doctor within 30 days, we will choose one for you.

Different types of doctors can serve as PCPs. A pediatrician treats children. Internal medicine doctors treat adults. Family practice doctors treat everyone. With this Handbook, you should have a Provider Directory that lists all the doctors, clinics, hospitals, labs, and others who work with PHP, including their address, phone number, and special training. The Provider Directory will also tell you which doctors and providers are taking new patients. You can also get a list of providers in your area on our website at www.phpcares.org.

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 an OB/GYN doctor listed in the Provider Directory. They can have routine checkups, follow-up care if needed, and regular care during pregnancy.

We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some people want to get their care from FQHCs because the centers have a long history in their neighborhood. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. You can also sign up with a PCP at one of the FQHCs that we work with, listed below. Just call Member Services at 1-855-747-5483 for help.

ADVANTAGE CARE DIAGNOSTIC AND TREATMENT CENTER
BEACON CHRISTIAN COMMUNITY HEALTH CENTER
CORNERSTONE FAMILY HEALTHCARE
HEARTSHARE WELLNESS
HOUSING WORKS HEALTH SERVICES
ICL HEALTHCARE CHOICES
JOSEPH P ADDABBO FAMILY HEALTH CENTER
LONG ISLAND SELECT HEALTHCARE
METRO COMMUNITY HEALTH CENTERS
NYU LUTHERAN FAMILY HEALTH CENTER
OPEN DOOR FAMILY MEDICAL CENTER
PREMIUM HEALTH

Many of our members get health care from the clinics at their OPWDD agency. PHP has a contract with all the OPWDD clinics in the counties we serve, so if you are happy with the doctors at your clinic, you can keep going there for your health care needs. These clinics are listed in our Provider Directory. If you need assistance in locating an OPWDD clinic, you can call your Care Coordination Organization (CCO) Care Manager or PHP Member Services. They will be happy to help you.

PCP Not Accepting New Patients

PCPs are busy, and sometimes they have so many patients to take care of that they cannot accept any new ones. This is a called a "closed panel." PCPs in PHP's provider network have to let us know when they are no longer accepting new patients so that we can tell our members to choose someone else. We also include this information in our Provider Directory.

If the PCP you want is not accepting new patients, or if you are having trouble finding a PCP who will see you, please call Member Services at 1-855-747-5483 and we will help you.

New Member Transition

If you were under the care of a doctor before joining PHP and the doctor is not listed in PHP's Provider Directory, you may be able to continue seeing the doctor for a while longer. These circumstances include:

- You are more than three months pregnant when you join PHP and you are getting prenatal care. In that case, you can keep your provider until after your delivery through post-partum care.
- At the time you join PHP, 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 PHP, you are 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 PHP, 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. PHP must tell you about any changes to your home care before the changes take effect.

In order for you to continue seeing a doctor who is not in our network, the doctor must agree to:

- Accept payment at regular Medicaid rates
- Follow PHP's quality assurance requirements
- Tell us about the care you receive
- Follow PHP's rules (policies and procedures)

We may also ask your doctor to join our network.

Choosing a Specialist as Your PCP

If you have a long-lasting illness that requires regular care from a specialist, you may be able to choose the specialist to serve as your PCP. If you are interested in having a specialist PCP, please call Member Services at 1-855-747-5483.

Changing Your PCP

You can change your PCP at any time for any reason. If you wish to change your PCP, please call Member Services at 1-855-747-5483 and PHP will help find the right PCP for your needs.

Your PCP Leaves PHP

If your PCP leaves PHP, we will tell you within 15 days after we learn about it. If you wish, you may continue to see the PCP after he or she leaves PHP if you are more than three months pregnant or if you are receiving an ongoing treatment for a medical condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing medical condition, you may continue your present course of treatment for up to 90 days.

Your doctor must agree to keep seeing you during this time. Your doctor must also agree to the following requirements:

- Accept the same rate of payment as before
- Follow PHP's quality assurance requirements
- Tell PHP about the care you receive
- Follow all of PHP's rules (policies and procedures)

If you wish to keep seeing your PCP after he or she leaves PHP, please call Member Services at 1-855-747-5483.

Importantly, your doctor may not be able to continue seeing you depending on the reason he or she left PHP, such as:

- The doctor caused harm to a patient
- The doctor was not honest with PHP or the Medicaid program
- The government took some form of action against the doctor

In these cases, you will have to choose a new doctor.

How to Get Regular Health Care

Regular health care means exams, check-ups, shots, or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It also means you and your PCP working together to keep you well or to see that you get the care and services 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. Your CCO Care Manager may also be able to help you. If you call after hours or weekends, leave a message and where or how you can be reached and someone will call you back as soon as possible.

If you are going to see your PCP for the first time, prepare for the appointment by making a list of your medical background, any medical problems you are having right now, any medications you are taking, and the questions you want to ask. Your PCP will want to know as much about your health and daily habits as possible.

If you want to see your doctor or it is time for a checkup or a shot or if you don't feel well, call your PCP to make an appointment. If you make an appointment and then are unable to keep it, call your PCP to re-schedule or cancel the appointment. Do not break an appointment without calling to let them know you will not be there. Doctors are busy, and the time they set aside to see you can be given to someone else if you let them know in advance. And remember that PHP Member Services staff can help you make appointments as well as cancel them.

Scheduling Appointments

If you call for an appointment, be sure to tell them the reason for the visit so they can be sure to schedule the appointment as soon as necessary. The following table describes the appointment wait times for various medical conditions:

Reason for Appointment	Timeframe
Adult baseline and routine appointment	Within three months
Urgent Care	Within 24 hours
Non-urgent sick visits	Within three days
Routine, preventive care	Within four weeks
First prenatal visit	Within three weeks during first trimester; Within two weeks during second trimester; Within one week during third trimester
First newborn visit	Within two weeks of hospital discharge
First family planning visit	Within two weeks
Follow-up visit after mental health/substance use disorder ER or inpatient visit	Within five days
Non-urgent mental health or substance use disorder visit	Within two weeks

How to Get Specialty Care and Referrals

If you need care that your PCP cannot give, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP and they will help you find a different specialist as soon as possible.

Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask PHP to approve before you can get them. Your PCP will be able to tell you what they are.

Standing Referrals

If you need to see a specialist for ongoing care, your PCP may be able to refer you for multiple visits or a certain length of time. This is called 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 also be able to arrange for your specialist to act as your PCP or refer you to a specialty care center that deals with the treatment of your illness. You can also call PHP's Member Services for help in getting access to a specialty care center.

Out-of-Network Referrals

If you are having trouble getting a referral you think you need, talk to your PCP or contact Member Services at 1-855-747-5483. If we do not have a specialist listed in our Provider Directory who can give you the care you need, we will arrange for you to see a specialist outside of PHP's network. This is called an "out-of-network referral." Your PCP or other provider must ask PHP for approval before you can get an out-of-network referral. If you or your PCP or other provider refers you to a provider who is not in our network and we approve the referral, you will not be responsible for any of the costs.

Your PCP can obtain a pre-authorization for out-of-network services by calling 1-855-769-2508. Timeframes for approving an out-of-network referral 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 PHP's network that can treat you. If you think our network provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a Plan Appeal. See page 34 to find out how.

Services That Do Not Need a Referral

You can get the following services from PHP without a referral:

Women's Health Care: You do not need a referral from your PCP to see another network provider with the appropriate qualifications if you:

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

The specialist provider must agree to PHP's policies and procedures for referrals and authorizations for services other than OB/GYN services and to provide services specified in a treatment plan (if any) approved by PHP. PHP will treat OB/GYN care and the ordering of OB/GYN items and services by the specialist provider in the same way as the authorization of the primary care provider.

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

Family Planning: You can get the following family planning services from your PCP or from another doctor without a referral from your PCP:

- Advice about birth control
- Birth control prescriptions

- Male and female condoms
- Pregnancy tests
- Sterilization
- Abortion
- Tests for sexually transmitted diseases (STDs)
- Breast or pelvic exams

You can choose where to get these services by using our Provider Directory and looking under Family Planning Services. You can also contact Member Services for assistance by calling 1-855-747-5483.

You can also go to a doctor or clinic outside of our network. Ask you PCP for a list of places to get these services. You can also call the New York State Growing Up Healthy Hotline at 1-800-522-5006 for information about family planning services near you.

HIV and STD Screening: You can get an HIV or STD test any time you have an office or clinic visit with your PCP or whenever you get family planning services from another doctor. You can also see a doctor who is not in PHP's network by using your Medicaid card. Please contact Member Services for assistance.

- To get free HIV testing or testing where your name is not given, call 1-800-541-AIDS (English) or 1-800-233-SIDA (Spanish).
- Some HIV 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 necessary. If your test is negative, we can help you learn to stay that way.

Eye Care: Your covered benefits include the needed services of an ophthalmologist, optometrist, and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Members diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. Simply make an appointment with one of our participating providers or contact your PCP or Member Services for assistance.

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 Disorder): We want you to get the mental health and drug or alcohol use disorder services you may need. If at any time you think you need help with mental health or substance use, you can see any behavioral health provider listed in our Provider Directory. This includes services like clinic and detox services. You do not need a referral from your PCP, but he or she can help you to choose where to get services. Member Services staff can also assist you with finding a behavioral health provider.

Smoking Cessation: You can get medication, supplies, and counseling without a PCP referral if you want help to quit smoking.

Emergency Services

PHP members are always covered for emergencies. An emergency means a medical or behavioral condition that:

- Comes on suddenly
- Has pain or other symptoms

An Emergency Condition is defined as:

- A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

  (a) Placing the health of the person afflicted with such condition (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy;

  (b) Serious impairment to such person's bodily functions;

  (c) Serious dysfunction of any bodily organ or part of such person; or

  (d) Serious disfigurement of such person.

Examples of an emergency include:

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

Examples of health issues that are **not** emergencies include:

- Colds
- Sore throat
- Upset stomach
- Minor cuts and bruises
- Sprained muscles

Other problems that are not medical emergencies are issues like family quarrels, a break-up, or wanting to use drugs or alcohol. These may seem like emergencies, but they are not a reason to go to the emergency room.

If you are not sure whether you should go to the emergency room, call your PCP and someone will either provide immediate assistance or call you back within 30 minutes or less. You can also call the Nurse Hotline for assistance. And finally, you can also contact Member Services at 1-855-747-5483, where a live person is available Monday through Friday from 8:00am to 6:00pm (except state holidays). At all other times, you will be given an option to connect to the Nurse Hotline where a trained nurse can help decide whether you should go to the emergency room. These professionals will listen to your explanation of the problem and tell you what to do at home and whether you should go to the doctor's office, an Urgent Care Center, or an emergency room.

You can also go to an Urgent Care Center instead of an emergency room for issues like sprained muscles, minor bleeding, upset stomach, and other problems that need attention but will not cause harm without immediate care. You can find an Urgent Care Center near you in the Provider Directory.

Your PCP can also arrange for an urgent care visit on the same or the next day. You can call your PCP at any time, day or night. If you cannot reach your PCP, call us at 1-855-747-5483 and let us know what is happening. We can help.

If You Have an Emergency

If you believe you have an emergency, call 911 or go to the nearest emergency room. You do not need approval from your PCP or PHP to go to the emergency room, even if the services are received outside of PHP's service area.

Again, if you are not sure whether you are experiencing an emergency, call your PCP, the Nurse Hotline, or Member Services at 1-855-747-5483.

If you are away from home when you have an emergency, call 911 or go to the nearest emergency room.

If you go to the emergency room, be sure to let us know as soon as possible so we can follow-up and make sure you have everything you may need.

REMEMBER

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

The Emergency Room should not be used for problems like the flu, sore throats, ear infections, a headache, an upset stomach, or other common health complaints.

If you have questions, call your PCP or PHP Member Services at 1-855-747-5483.

Urgent Care

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

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

You can get an appointment for an urgent care visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-855-747-5483. 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 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. If you receive emergency care within the US, all services related to the emergency will be covered by PHP and you do not have to pay.

WE WANT TO KEEP YOU HEALTHY

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

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

Call Member Services at 1-855-747-5483 or visit our website at www.phpcares.org to find out more and get a list of upcoming classes.

YOUR BENEFITS AND PHP PROCEDURES

The rest of this Handbook is for your information when you need it. It lists the services that we cover (pay for) as well as the services that we do not cover. Most of our members also get services from OPWDD or the Department of Education. PHP does not cover the services that you receive from OPWDD or the Department of Education, but we want to work closely with you, your family or other caregivers, and your CCO Care Manager or IEP Coordinator to make sure you are getting the services and supports you need. If you have a complaint, the Handbook tells you what to do. The Handbook also has other information you may find useful. Please keep this Handbook handy for when you need it and call us whenever you have a question or concern at 1-855-747-5483.

Services Covered by PHP

All services must be delivered by providers who are in PHP's network and must be medically or clinically necessary and provided or referred by your PCP or PHP. Please call our Member Services Department at 1-855-747-5483 if you have any questions or need help with any of the services listed below.

Physical Health Services

Regular Medical Care:

- Office visits with your PCP
- Referrals to specialists
- Eye/hearing exams

Preventive Care:

- Well-baby and well-child care
- Well-woman care
- Regular check-ups
- Shots for children from birth through childhood
- Pneumonia and flu vaccines
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children and young adults under age 21
- Smoking cessation counseling
- HIV education and risk reduction

Maternity Care:

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

Specialty Care:

- Includes the services of most specialists including therapists (occupational, physical, and speech) and behavioral health providers (see below). In most cases members can schedule an initial specialist appointment without a referral. Please call your PCP or Member Services at 1-855-747-5483 for more information.

Emergency Care:

- All emergency room and urgent care center services as well as follow-up care received in an emergency room, inpatient hospital, or other setting

Hospital Care:

- Inpatient care
- Outpatient care, including outpatient surgeries
- Lab, x-ray, and other screenings/tests

Residential Health Care Facility Services:

- Skilled nursing facility services (nursing home), including:
  - ◊ Medical supervision
  - ◊ 24-hour nursing care
  - ◊ Assistance with activities of daily living (ADLs)
  - ◊ Physical, occupational, and speech therapy
  - ◊ **Note**: PHP covers long-term placement in a participating nursing facility when medically necessary for members 21 years of age and older
- Rehabilitation facilities (short-term)

Home Health Care:

- One (1) medically necessary post-partum home health visit, with additional visits as necessary for high-risk women
- At least two (2) visits for high-risk infants (newborns)
- Other home health visits as determined to be medically necessary and referred by the member's PCP or specialist

Personal Care/Home Attendant Services:

- As determined to be medically necessary and ordered by your PCP or other doctor and not available through OPWDD (these services may also be arranged through the Consumer-Directed Personal Assistance Services (CDPAS) program)

Personal Emergency Response System (PERS):

- Only available to members receiving personal care/home attendant services through PHP

Adult Day Health Care Services:

- Requires the recommendation of your PCP and is not available through OPWDD. Includes assistance with normal daily activities such as dressing and going to the bathroom.

AIDS Adult Day Health Care Services:

- Requires a referral from your PCP or other doctor. These services include:
  - ◊ General medical and nursing care
  - ◊ Substance use disorder supportive services
  - ◊ Mental health supportive services
  - ◊ Individual and group nutritional services
  - ◊ Structured socialization, recreational, and wellness/health promotion activities

Directly Observed Therapy for Tuberculosis Disease:

- Provides observation and dispensing of medication, assessment of any adverse reactions to medications, and case follow-up

Hospice Care:

- Must be medically necessary and arranged through PHP
- Provides support services and some medical services to members who are ill and expect to live for one (1) year or less
- Services are available either at home or in a hospital or nursing facility
- Children under age 21 can also receive medically necessary curative services and palliative care

Other covered services:

- Durable Medical Equipment (DME) including hearing aids, prosthetics, and orthotics
- Court-ordered services
- Case management
- Assistance with accessing community-based services
- Federally Qualified Health Center services
- Podiatry services for children under age 21 and persons with diabetes

Behavioral Health Care

Behavioral health services include mental health and substance use disorder treatment as well as rehabilitation services. Specific services include:

- Mental Health Care
- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment

- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services within a community home or family-based treatment
- Continuing day treatment
- Personalized Recovery Oriented Services
- Assertive Community Treatment Services
- Individual and group counseling
- Crisis intervention services
- Substance Use Disorder Services
- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid, including Methadone Maintenance, Treatment
- Residential Substance Use Disorder Treatment
- Outpatient alcohol and drug treatment and detox services

Children's Family Treatment and Support Services

Use your PHP Care Preferred benefit card to get Children and Family Treatment and Support Services. These services include:

- **Other Licensed Practitioner (OLP).** This benefit lets you get individual, group, or family therapy where you are most comfortable.

- **Psychosocial Rehabilitation (PSR).** This benefit helps you relearn skills to help you in your community. This service was called "Skill Building."

- **Community Psychiatric Supports and Treatment (CPST).** This benefit helps you stay in your home and communicate better with family, friends and others. This service was called "Intensive In Home Services," "Crisis Avoidance Management & Training," or "Intensive In Home Supports and Services."

If you are under 21 years old and have federal Social Security Insurance disability status or have been determined Social Security Insurance-Related by New York State, use your State Medicaid Card for these Children's Family Treatment and Support Services.

Medications/Drugs

Most covered drugs are only available by prescription, are used or sold in the United States, and must be used for medically accepted indications. Prescription drugs covered by Partners Health Plan are listed on our website, which includes all generic drugs covered under New York Medicaid as well as many brand-name drugs, non-preferred brands, and specialty drugs. In addition, NYS Medicaid provides coverage for barbiturates,

benzodiazepines, some prescription vitamins, and a number of non-prescription drugs. A complete list of the medications we cover is included on the PHP website at www.phpcares.org.

Some of these drugs must be prior approved or will only be approved once other medications have been tried first. There may also be limits on how much of the medication will be covered. You should obtain covered drugs from a network pharmacy with a prescription from your doctor.

Covered medications include:

- Prescription drugs
- Over-the-counter medications
- Insulin and diabetic supplies
- Smoking cessation agents, including over-the-counter products
- Hearing aid batteries
- Enteral formula
- Medical and surgical supplies

PHP has a contract with a separate company called "PerformRx" to manage our drug benefit. If you or your doctor have questions about covered drugs, the PerformRx phone number is included on your PHP Member ID Card (1-833-669-7673 for Member and Pharmacy Services). The pharmacies in our network are listed in the Provider Directory. You can also contact PHP Member Services at 1-855-747-5483 with any questions or concerns about drug benefits or to get help with locating a network pharmacy near you.

Dental Care

PHP recognizes that good dental care is vitally important to your overall health. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings, and other services to check for any issues that may require treatment and/or follow-up care. Members under age 21 are also eligible for certain orthodontic services such as braces or to fix a cleft palette or cleft lip. Members do not need a referral to see a dentist. The dentists in PHP's network are listed in the Provider Directory.

PHP contracts with a separate company called "BeneCare" to manage our dental benefits. BeneCare can be contacted by calling 1-800-903-3335. PHP can also assist with scheduling dental appointments by contacting our Member Services Department at 1-855-747-5483.

Show your PHP 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.

Eye Care

Eye care or vision services are available to PHP members through our contract with NVA. Covered services include:

- Eye exams (typically every 2 years unless needed more frequently)
- Glasses (every 2 years unless needed more often), including the replacement of lost or destroyed glasses, including repairs as appropriate
- Contact lenses, polycarbonate lenses, artificial eyes
- Low vision exam and vision aids
- Optometrist services
- Ophthalmologist services and ophthalmic dispensers
- Specialist referrals for eye diseases or defects

NVA can be contacted at 1-877-865-7925. You can also contact Member Services at 1-855-747-5483 for assistance with vision services.

Benefits Either from PHP or Medicaid (Out-of-Network)

For some services, you can choose where to get the care. You can get these services by using your PHP Member ID card or you can also go to out-of-network providers who will take your Medicaid Benefit card. You do not need a referral from your PCP to get these services. Call us if you have questions at 1-855-747-5483.

- **Family Planning**: You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can also visit one of PHP's family planning providers as well. Either way, you do not need a referral from your PCP. You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted disease (STD) 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 STD Screening**: You can get this service any time from your PCP or PHP providers. 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 PHP does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

For Individuals with Intellectual and Developmental Disabilities:

- Long-term therapies
- Day treatment
- Housing services
- Care Coordination Organization (CCO)

Non-Covered Medical Services

Non-covered services include services that are not available through PHP or from Medicaid or services that were delivered without prior approval when it was required. Non-covered services also include services that members receive from OPWDD or the Department of Education instead of PHP as well as inappropriate utilization of the emergency room.

Non-covered services include:

- Cosmetic surgery if not medically necessary (Note: New York Medicaid does not cover breast reconstruction surgery for breast cancer)
- Podiatry services for adults over age 21, unless they are diabetic
- Personal and comfort items
- Infertility treatments
- Out-of-network services without prior approval except for emergent/urgent care

Before delivering non-covered services, providers should always inform you and/or your family member or other caregiver that PHP will not pay for the service and it will instead be charged to you.

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 PHP at 1-855-747-5483 right away. PHP can help you understand why you may have gotten a bill. If you are not responsible for payment, PHP will contact the provider and help fix the problem for you. You have the right to ask for a Fair Hearing if you think you are being asked to pay for something Medicaid or PHP should cover. See the Fair Hearing section later in this Handbook.

SERVICE AUTHORIZATIONS

Prior Authorization and Timeframes

There are some treatments and services for which you need to get PHP's approval before you receive them or to continue receiving them. This is called "**prior authorization**." You or your doctor or someone you trust can ask for prior authorization. The following treatments and services must be approved before you get them:

- Some outpatient hospital services
- Bariatric surgery
- Dialysis
- Durable medical equipment
- Enteral and Parenteral Nutrition
- Home care services
- Hyperbaric oxygen therapy
- Inpatient services
- Lithotripsy
- Non-emergent air ambulance
- Oxygen equipment – respiratory therapy
- Prosthetics and orthotics
- Skilled nursing facility admissions
- Certain medications
- Transplant evaluation
- Experimental or investigational services/procedures

Prior authorization (or Utilization Review or UR) will occur whenever judgments pertaining to medical necessity and the provision of services or treatments are rendered. If you have questions about any of these services or treatments, please call Member Services at 1-855-747-5483 and they will gladly provide assistance.

Prior Authorization Requests

Asking for approval of a treatment or service is called a "prior authorization request." To get approval for these treatments or services your doctor must call PHP's UM Department at 1-855-769-2508, which has a live person available during normal business hours and an answering machine at all other times. If necessary, your doctor can call for an approval after hours and on weekends by leaving a message at this number. You will also need to get prior authorization if you are already getting one of these services, but need to continue receiving the service or increase the amount of care you have been getting. This is call **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 needed and right for you. They do this by checking your treatment plan against medically acceptable standards.

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

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

We will **fast track** your review if:

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

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

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

Timeframes for prior authorization requests:

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

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

Timeframes for concurrent review requests:

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

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

Special timeframes for other requests:

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

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

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

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-855-769-2508 or writing to:

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

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

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

Other Decisions About Your Care:

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

Timeframes for other decisions about your care:

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

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our providers that might affect your use of health care services. You can call Member Services at 1-855-747-5483 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways:

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

You Can Help with Plan Policies

We value your ideas and want you to tell us how we might improve. If you have ideas or suggestions, please tell us about them. You can do so by going to one of our Member Advisory Committee meetings or by simply calling Member Services at 1-855-747-5483.

INFORMATION FROM MEMBER SERVICES

The following is a list of the types of information you can get by calling Member Services at 1-855-747-5483. Our trained Member Services staff will gladly answer any of your questions or provide help with a problem.

- A list of names, addresses, and titles of PHP's Board of Directors, Officers, Controlling Parties, and Partners
- A copy of the most recent certified financial statements/balance sheets, summaries of income and expenses
- Information from the Department of Health regarding member complaints involving PHP
- How we keep your medical records and member information private
- In writing, we will tell you how PHP checks on the quality of care to our members
- We will tell you which hospitals our health providers work with
- If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by PHP
- If you ask in writing, we will tell you the qualifications needed and how health care providers can apply to be part of PHP
- If you ask, we will tell you:
  - ◊ Whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, information on the type of incentive arrangements we use
  - ◊ Whether stop-loss protection is provided for physicians and physicians groups
  - ◊ Information about how our company is organized and how it works

Keep Us Informed

Call Member Services at 1-855-747-5483 whenever these changes happen in your life:

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

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

DISENROLLMENTS AND TRANSFERS

1. If YOU want to leave the Plan

At present, enrolling in PHP is voluntary. So, if you want to leave PHP you can do so at any time by calling Member Services at 1-855-747-5483 or calling the Local Department of Social Services (LDSS) in your area (the Human Resources Administration or HRA in NYC) or calling New York Medicaid Choice at 1-800-505-5678. No one will try to make you change your mind, but we would like to know why you decided to leave.

If you decide to leave PHP, you can enroll in another health plan or, if you are receiving OPWDD waiver services, you can use your Medicaid card to get health care services. If you are not receiving OPWDD services, you may be required to join another Medicaid managed care plan. If you are not sure, please call Member Services and we will explain your options.

To change plans:

> If you live in NYC, Nassau, Rockland, Westchester, or Suffolk, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans.

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

2. You Could Become Ineligible for Medicaid Managed Care

You may have to disenroll from PHP if you:

- Move out of our service area (Boroughs of NYC, Nassau, Rockland, Suffolk, or Westchester Counties)
- Enroll in a different Medicaid managed care plan
- Lose Medicaid eligibility
- Get placed in foster care
- Go to prison

3. We Can Ask You to Leave Partners Health Plan

You can also lose your PHP membership, if you often:

- Refuse to work with PHP to get your care
- Fail to keep appointments
- Go to the emergency room for non-emergency care such as a sore throat or a cough
- Don't follow PHP rules

- Do not tell us the truth when filling out forms or answering questions
- Cause abuse or harm to other members, providers, or PHP staff
- Act in ways that make it hard for PHP or our providers to do our best for you and other members even after we have tried to fix the problems

Eligible for Medicare

If you become eligible for Medicare, in addition to Medicaid, and want to remain in PHP, you can either stay in your current PHP plan, or you can transfer to PHP's FIDA-IDD Plan that is designed for people with intellectual or other developmental disabilities who are eligible for both Medicaid and Medicare. If this happens, please call Member Services at 1-855-747-5483 and we will explain your options.

COMPLAINTS AND APPEALS

Plan Appeals

As explained earlier in this Handbook, 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 "**prior authorization request**." Any decision by PHP to deny a prior 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 a decision we make about your care, there are steps you can take.

- **Your provider can ask for a reconsideration**: If we made a decision that your prior authorization request was not medically necessary or was experimental or investigational; and we did not talk to your doctor about it, your doctor may ask to speak with our Chief Medical Officer. The Chief Medical Officer will talk to your doctor within one work day.
- **You can file a Plan Appeal**

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

- You have **60 calendar days** from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services 1-855-747-5483 if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

Aid to Continue while appealing a decision about your care:

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

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

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

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

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-855-769-2508.

Give us your information and materials by phone, fax, email, mail, or online**:**

Phone……1-855-769-2508
Fax……1-855-769-2509
Email……appeals@phpcares.org
Mail……6303 Commerce Dr., Ste 180
Irving, TX 75063
Online……www.phpcares.org

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.

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.
  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.

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

- 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.

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

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

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in writing. Call PHP at 1-855-769-2508 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.
- **If you think our Final Adverse Determination is wrong**:
    - you can ask for a Fair Hearing. See the Fair Hearing section of this Handbook.
    - for some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this Handbook.
    - you may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals:

- **Standard Plan Appeals**: If we have all the information we need, we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.

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

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

- 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
- 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
- If your request was denied when you asked for home health care after you were in the hospital
- 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 1-855-769-2508 or writing to us.

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

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

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

External Appeals

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

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

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

Before you ask for an External Appeal:

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

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

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-855-747-5483 if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' web site at www.dfs.ny.gov.
- Contact the health plan at 1-855-747-5483

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

You can get a faster decision if:

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

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

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

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

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

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

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

Fair Hearings

In some cases, you may ask for a Fair Hearing from New York State.

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving Partners Health Plan.

- You are not happy with a decision we made about care you are getting. You feel the decision limits your Medicaid benefits or that we did not make the decision in a reasonable amount of time.

- You are not happy about a decision we made that denied care you wanted. You feel the decision limits your Medicaid benefits.

- You are not happy about a decision we made to deny payment for care you received. You feel the decision limits your Medicaid benefits.

- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with Partners Health Plan. If Partners Health Plan agrees with your doctor, you may ask for a state Fair Hearing.

- The decision you receive from the Fair Hearing officer will be final.

If the services you are now getting are going to be reduced, stopped, or restricted, you can choose to ask to continue the services your doctor ordered while you wait for your case to be decided. You must ask for a Fair Hearing **within 10 days** from the date of the notice that says your care will change or by the time the decision takes effect. However, if you choose to ask for services to be continued, and the Fair Hearing is decided against you, you may have to pay the cost for the services you received while waiting for a decision.

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

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

When you ask for a Fair Hearing about a decision PHP 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 decision. 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 1-855-747-5483 to ask for it.

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

Complaint Process

We work hard to make sure your health care needs are met on a timely basis with courtesy and professionalism. If you have a problem or are unhappy with some aspect of your care, call or write to Member Services. Once we learn about them, most problems can be solved right away.

If you have a problem or a dispute with the care or services you receive through PHP, including disputes that are not related to a prior authorization request, you or someone you trust can file a complaint (or grievance) by calling us at 1-855-747-5483 or writing to us at P.O. Box 16309, Lubbock, TX 79490. Any oral or written complaint that we receive, including complaints about referrals or covered benefits, will be handled according to the complaint process described below. If you need our help because of a hearing or vision impairment, or if you need translation services, or help filing the forms, we can help you. We will not make things hard for you or take any action against you for filing a complaint. You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125 or write to:

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

You may also contact your local Department of Social Services (LDSS or HRA in NYC) with your complaint at any time. You can also 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 PHP

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 a complaint by phone, call Member Services at 1-855-747-5483, Monday through Friday from 8:00am to 6:00pm, except state holidays. If you call us after hours, leave a message and we will call you back the next work day. If we need more information, we will tell you. You can also write to us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

PHP Care Preferred Complaints
P.O. Box 16309
Lubbock, TX 75063

What happens next:

If we don't solve the problem right away, we will send you a letter within 15 work days. The letter will tell you:

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

You can also provide information to be used while reviewing your complaint in person or in writing. Call PHP at 1-855-747-5483 if you are not sure what information to give us.

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

After we review your complaint:

- We will let you know our decision in 45 days after 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, including the clinical rationale if applicable (with the exception of protected peer review information).
- When a delay might risk your health, we will let you know our decision within 48 hours after we have all the information we need to answer your complaint, but you will hear from us in no more than seven (7) days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will also get a letter in three (3) work days.
- You will be told how to appeal our decision if you are not satisfied with our decision 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.

If we were able to make a decision, we will send you a letter that will give you a full explanation and reasons for our decision, including the clinical reasons if your complaint was medically related.

Complaint Appeals

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of PHP, you and/or your family or authorized representative has a right to:

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation.
- Be told where, when, and how to get the services you need from PHP.
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand.
- Get a second opinion about your care.
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you.
- Refuse care and be told what you may risk if you do.
- Get a copy of your medical record, and talk about it with your PCP, 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 PHP 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 PHP member, you and/or your family or authorized representative agree to:

- Work with your PCP to guard and improve your health.
- Find out how your health care system works.
- Listen to your PCP's advice and ask questions when you are in doubt.
- Call or go back to your PCP if you do not get better, or ask for a second opinion.
- Treat health care staff with the respect you expect yourself.

- Tell us if you have problems with any health care staff. Call Member Services.
- Keep your appointments. If you must cancel, call as soon as you can.
- Use the emergency room only for 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 he or she knows what you want.

CPR and DNR

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

Organ Donor Card

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

MOLST Form for OPWDD Participants

All of PHP's network providers must comply with all state rules and regulations—including OPWDD regulations, if applicable—relating to Advance Directives and must provide care and treatment according to your and/or your representative's wishes.

In 2011, OPWDD approved the use of the revised Medical Orders for Life-Sustaining Treatment or MOLST form for people with intellectual and other developmental disabilities (I/DD). However, the MOLST form must be accompanied by the MOLST Legal Requirements Checklist.

Use of this checklist is required for individuals with I/DD who are not able to make their own health care decisions and do not have a health care proxy. Medical decisions which involve the withholding or withdrawing of life-sustaining treatment (LST) must comply with the process described in the Health Care Decisions Act for persons with I/DD. This includes DNR orders.

The advantage of the MOLST form is that it is transferable to other, non-hospital settings. Accordingly, a DNR issued on a MOLST form is effective not only in hospitals and nursing homes but in community settings as well. The MOLST includes medical orders and instructions for intubation and mechanical ventilation, future hospitalization/transfer, etc.

Please call Member Services for more information about this important topic.

YOUR RIGHT TO PRIVACY

THIS SECTION 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. 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 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

Rules for Sharing Your Information

We can share your PHI with your family or with a person you choose 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
- 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.phpcares.org or call Member Services at 1-855-747-5483 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 also 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

Protecting 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 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.

PHP's Responsibilities

- 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 give us 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.

We May Contact You

You agree that PHP, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system and/or a prerecorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

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 internet at www.phpcares.org.

If you have any questions or concerns about privacy rules or your rights, please call Member Services at 1-855-747-5483.

Race, Ethnicity, and Language

We receive race, ethnicity and language information about you from the state Medicaid agency and OPWDD, as applicable. 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
- 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.

Partners Health Plan follows Federal civil rights laws. We do not discriminate against people because of their:

- Race
- Color
- National Origin
- Disability
- Age
- Sex or Gender Identity

This means we won't exclude you or treat you differently because of these things.

IMPORTANT PHONE NUMBERS

Partners Health Plan Member Services.....1-855-747-5483

Member Services TTY/TDD 711

Pharmacy Member and Pharmacy Services.....1-833-669-7673

BeneCare (Dental) Member Services.....1-800-903-3335

NVA (Vision) Member Services.....1-877-865-7925

24/7 Nurse Hotline 1-855-769-2507

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

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

NOTICE OF NON-DISCRIMINATION

Partners Health Plan complies with Federal civil rights laws. **Partners Health Plan** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Partners Health Plan provides the following:

- FREE AIDS AND SERVICES TO PEOPLE WITH DISABILITIES TO HELP YOU COMMUNICATE WITH US, SUCH AS:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Partners Health Plan at** 1-855-747-5483. For TTY/TDD services, call 711.

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

Mail:	655 Third Ave, 2nd Floor, New York, NY 10017
Phone:	1-855-747-5483 (for TTY/TDD services, call 711
Fax:	646-892-4810
In person:	655 Third Ave, 2nd Floor, New York, NY 10017
Email:	complaints@phpcares.org

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

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

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-855-747-5483, TTY/TDD 711.	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-747-5483, TTY/TDD 711.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-747-5483, TTY/TDD 711.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-747-5483 رقم هاتف الصم والبكم TTY/TTD 711	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-855-747-5483, TTY/TDD 711. 번으로 전화해주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-747-5483 (телетайп: 711).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-747-5483, TTY/TDD 711.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-747-5483, TTY/TDD 711.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-747-5483, TTY/TDD 711..	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-747-5483, TTY/TDD 711.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-747-5483, TTY/TDD 711.	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-747-5483, TTY/TDD 711.	Tagalog
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