

Member Handbook, and Other Important Documents

This handbook is revised for July 2017.

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

Member Services: 1-800-650-4359

TTY: 1-800-662-1220

**SERVICE AUTHORIZATION AND APPEAL CHANGES
EFFECTIVE 6/1/2018**



(WMHP)

LANGUAGE ASSISTANCE

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

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE UPDATED INFORMATION

Behavioral Health Appointment Standards

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

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

If you are unable to schedule a behavioral health appointment within the appointment wait times listed above, you, or your designee, may submit an access complaint to Univera MyHealthSM Plus by telephone, 1-800-650-4359 and in writing to Univera Healthcare, PO Box 211256, Eagan, MN 55121 to resolve this issue.

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

Behavioral Health Access Complaint

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

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

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

- After screening through the SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.
- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:
 - Housing and utilities support:
 - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
 - Mold, pest remediation, and asthma remediation services.
 - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
 - Providing small refrigeration units needed for medical treatment.
 - Medical Respite.
 - Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.
 - Nutrition support:
 - Getting help from a nutrition expert who will help you choose healthy foods to meet your health needs and goals.
 - Getting prepared meals, medically tailored meals, food prescriptions, fresh produce, or non-perishable grocery items.
 - Providing cooking supplies like pots, pans, utensils, a microwave, and a refrigerator to prepare meals.
 - Transportation services:
 - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting

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

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

Getting in Contact with an SCN in your area:

1. You may call the health plan's member services 1-800-650-4359 (TTY users 711) and we will connect you to the SCN in your area.
2. You may call the SCN serving your county and request a screening or more information. See the SCN contact information in the chart below.
3. You may also visit their website to begin a self-screening.

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

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

SCN	Counties	Phone number
Western New York Integrated Care Collaborative Inc.	Cattaraugus, Chautauqua, Erie, Niagara	716-431-5100
	https://wnyscn.org/	

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Chronic Disease Self-Management Program (CDSMP) for Arthritis

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

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

This program may help prevent you from:

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

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

Eligibility

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

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

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

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Doula Services

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

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

What is a Doula?

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

What Doula Services are Available?

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

Doula services may include:

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

Eligibility

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

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

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

Electronic Notice Option

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

We can send you these notices to you by email.

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

Phone.....1-800-650-4539

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

When you contact us, you must:

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

Univera Healthcare MyHealth PlusSM will let you know by mail that you have asked to get notices electronically.

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE ADDITIONAL SERVICES

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

- Through this SCN, you and your child can meet with a Social Care Navigator who can check your eligibility for services that can help with your health and well-being. They will ask you some questions to see where you might need some extra support.
- If you or your child qualify for services, the Social Care Navigator can work with you to get the support you need. You may qualify for more than one service, depending on your situation. These services include:
 - Housing and utilities support:
 - Installing home modifications like ramps, handrails, grab bars to make your home accessible and safe.
 - Repairing and fixing water leaks to prevent mold from growing in your home.
 - Sealing holes and cracks to prevent pests from entering your home.
 - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
 - Helping you find and apply for safe and stable housing in the community.
 - Nutrition support:
 - Getting help from a nutrition expert who will give you guidance and support in choosing healthy foods to meet your health needs and goals.
 - Getting prepared meals, fresh produce, or grocery items delivered to your home for up to six (6) months. These food items will be tailored to your specific health needs.
 - Providing cooking supplies like pots, pans, microwave, refrigerator, and utensils to prepare meals.
 - Transportation services:
 - Helping you with access to public or private transportation to places approved by the SCN such as: going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

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

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED

Benefits You Can Get From Univera MyHealthSM Plus OR With Your Medicaid Card

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

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. You can visit one of our family planning providers as well. Either way, you do not need a referral from your PCP. You can get birth control drugs, birth control devices (IUDs and diaphragms) that are available with a prescription, plus emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services. You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment, and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

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

Get These Services From Univera MyHealthSM Plus WITHOUT A Referral

Women's Health Care

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

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

Family Planning

- You can get the following family planning services: advice about birth control, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, and an abortion. During your visits for these things, you can also get tests for sexually transmitted infections, a breast cancer exam, or a pelvic exam.

- You do not need a referral from your PCP to get these services. In fact, you can choose where to get these services. You can use your Univera MyHealthSM Plus ID card to see one of our family planning providers. Check our Provider Directory or call Member Services for help in finding a provider.
- Or, you can use your Medicaid card if you want to go to a doctor or clinic outside our plan. Ask your PCP or Member Services 1-800-650-4359 for a list of places to go to get these services. You can also call the New York State Growing Up Healthy Hotline (1-800-522-5006) for the names of family planning providers near you.

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

The pharmacy benefit section of your member handbook will no longer be valid after April 1, 2023. Instead, refer to the information below.

PHARMACY BENEFIT CHANGE:

Starting April 1, 2023, your prescriptions will not be covered by Univera MyHealthSM Plus. They will be covered by Medicaid NYRx, the Medicaid pharmacy program.

Most pharmacies in New York State take the Medicaid NYRx pharmacy program. If your pharmacy does not take Medicaid, you may:

- Ask your doctor to send a new prescription to a pharmacy that takes Medicaid NYRx pharmacy program, or
- Ask your pharmacist to transfer a refill to a pharmacy that takes Medicaid NYRx pharmacy program, or
- Locate a pharmacy that takes Medicaid NYRx at: <https://member.emedny.org/>.

You will need to show the pharmacist either your Medicaid Card **or** your Health Plan Card. This will tell them your Client Identification Number (CIN).

Medicaid NYRx has a list of covered drugs. Over-the-counter drugs and most drugs are on the list. This list of covered drugs can be found at:

<https://www.emedny.org/info/formfile.aspx>.

- Some drugs need prior approval before they can be filled. This list will tell you if a drug needs prior approval. Your doctor will call to get prior approval.
- If your drug is not on this list:
 - Your doctor can ask Medicaid for approval to let you get the drug, or
 - Your pharmacist can talk to your doctor about changing to a drug that is on the list.

Medicaid NYRx pharmacy plan also has a preferred drug list. This list can be found at: https://newyork.fhsc.com/downloads/providers/NYRx_PDP_PDL.pdf.

- If you need a non-preferred drug, please contact your pharmacist or doctor so that they can get approval for you to get this drug.

The Medicaid copayment structure is not changing. Your copayment might change depending on if the drug is preferred or non-preferred.

Your pharmacy benefit also covers certain supplies:

- A list of covered supplies can be found at: <https://member.emedny.org/>.

- A list of preferred diabetic meters and test strips can be found at:
https://newyork.fhsc.com/downloads/providers/NYRx_PDSP_preferred_supply_list.pdf
 - You will need to change to a preferred diabetic meter and test strip.

Do you have questions or need help? The Medicaid Helpline can assist you. They can talk to you in your preferred language. They can be reached at 1-800-541-2831 TTY 1-800-662-1220.

They can answer your call:

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

There are updates to your member handbook:

The handbook has been updated to include resource information and important phone numbers for Orleans County.

Transportation

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

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

Orleans County.....1-866-260-2520

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

Important Phone Numbers and Information

Orleans County Department of Social Services:

14016 Route 31, Albion, NY 14411-9365.....1-585-589-7000

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE ADDITIONAL SERVICES

Dental Services

Starting **January 31, 2024**, Univera MyHealth Plus will be covering crowns and root canals in certain circumstances so that you can keep more of your natural teeth.

In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are necessary. This will make it easier for you to access these dental services.

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Medically Tailored Meals Services

We're proud to offer benefits and services that help you live a healthy life. Starting October 1, 2023, you can join a no-cost Medically Tailored Meals program that provides healthy meals straight to your home.

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

- Help from a registered dietitian and nutritionist. This person is a food and nutrition expert and will help give guidance and support in choosing healthy foods.
- Up to two meals per day delivered to your home for six months at a time. You may be able to continue receiving meals as long as you are eligible for this program. These meals are tailored for your specific health needs and can help you gain access to healthy, nutritious foods.

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

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

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO UPDATE SOME SERVICES

Gambling Disorder Treatment Provided by Office of Addiction Services and Supports (OASAS) Certified Programs.

Starting **January 1, 2023**, Univera Healthcare MyHealth PlusSM will cover Gambling Disorder Treatment provided by Office of Addiction Services and Supports (OASAS) certified programs.

You can get Gambling Disorder Treatment:

- face-to-face; or
- through telehealth.

If you need Gambling Disorder Treatment, you can get them from an OASAS outpatient program or if necessary, an OASAS inpatient or residential program.

You do not need a referral from your primary care provider (PCP) to get these services. If you need help finding a provider, please call Univera Healthcare MyHealth PlusSM member services at the number listed below.

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE MORE SERVICES

Home Delivered Medically Tailored Meals

Medically tailored meals are based on certain health needs. They are pre-cooked, prepared, and brought straight to your home. Members may get up to 21 meals per week. Meals are brought to your home every week for up to 6 months.

Starting **January 1, 2023**, My Health PlusSM will cover Medically Tailored Meals (MTM) **for members who:**

- Are at least 18 years old,
- Have a safe place to store and heat meals,
- Are limited in the ability to perform actions of daily life, such as:
 - meal preparation
 - trouble moving from place to place without assistance
 - food shopping; or
 - bathing.
- Have cancer, diabetes, heart failure, HIV or AIDS,
- Have a medical provider or an Excellus BlueCross BlueShield case manager referral for the MTM program, and
- One of the following events happened over the last 12 months because of cancer, diabetes, heart failure, HIV or AIDS:
 - At least 2 in-patient hospital stays, or
 - At least 5 emergency room visits (not urgent care visits), or
 - At least 1 inpatient hospital stay **and** at least 4 emergency room visits (not urgent care visits)

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

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO UPDATE SOME SERVICES

Behavioral Health Community Oriented Recovery and Empowerment (CORE) Services.

Starting **February 1, 2022**, four Adult Behavioral Health Home and Community Based Services (BH HCBS) will be changing to Community Oriented Recovery and Empowerment (CORE) Services. MyHealth PlusSM will cover CORE Services. You can use your MyHealth PlusSM plan card to get these CORE Services.

New York State is making this change because CORE Services are easier to get than BH HCBS. Eligible members can get CORE Services through a recommendation from a qualified provider.

The services moving from BH HCBS to CORE Services are:

Psychosocial Rehabilitation (PSR)

This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.

Community Psychiatric Supports and Treatment (CPST)

This service helps you manage symptoms through counseling and clinical treatment.

Empowerment Services – Peer Supports

This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:

- live with health challenges and be independent,
- help you make decisions about your own recovery, and
- find natural supports and resources.

Family Support and Training (FST)

This service gives your family and friends the information and skills to help and support you.

What are the changes from BH HCBS to CORE Services?

These CORE Services are almost the same as they were in BH HCBS. There are two changes:

1. You now have more options for services to support goals related to work and school. You can work with a CORE PSR provider to help you:
 - get a job or go to school while managing mental health or addiction struggles;
 - live independently and manage your household; and

- build or strengthen healthy relationships.
2. Short-term Crisis Respite and Intensive Crisis Respite are now called Crisis Residential Services and are still available.

These seven services are still available under BH HCBS:

- Habilitation
- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Non-Medical Transportation

Will I have to change my BH HCBS provider to get CORE Services?

If you were getting CPST, PSR, FST or Peer Support as BH HCBS before **February 1, 2022**, you can keep getting the same services from your provider under CORE. Your provider will talk to you about any changes that affect you. You can also ask your care manager for help.

Do I need an assessment for BH HCBS?

Yes, you need to do the New York State Eligibility Assessment with your care manager or recovery coordinator to get a BH HCBS.

Do I need an assessment for CORE Services?

No, you do not need the New York State Eligibility Assessment to get CORE Services. You can get a CORE service if it is recommended for you by a qualified provider, like a doctor or social worker. The qualified provider may want to discuss your diagnosis and needs before making a recommendation for a CORE service.

How do I find a qualified provider to recommend me for CORE Services?

Your primary care provider or therapist may be able to make a recommendation for CORE Services. If you need help finding a qualified provider, contact member services at the number below. You can also ask your care manager for help.

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

Medicaid Managed Care Handbook Language

Specialty Care

Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST)

In anticipation of a **January 1, 2021**, start date Univera MyHealth plan will remove service limits on physical therapy (PT), occupational therapy (PT), and speech therapy (ST). Instead, Univera MyHealth plan will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE NEW SERVICES

Crisis Residence Services for Children and Adults

Starting **December 1, 2020**, Univera Healthcare MyHealth PlusSM will pay for Crisis Residence services. These are overnight services. These services treat children and adults who are having an emotional crisis. These services include:

Residential Crisis Support

This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

Intensive Crisis Residence

This is a treatment program for people who are age 18 or older who are having severe emotional distress.

Children's Crisis Residence

This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

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

YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE THIS INFORMATION

Starting **April 1, 2020**, your maximum pharmacy co-payment (co-pay) will be \$50 per quarter year. The co-pay maximum re-sets each quarter, regardless of the amount you paid last quarter.

The quarters are:

- First quarter: January 1 – March 31
- Second quarter: April 1 – June 30
- Third quarter: July 1 – September 30
- Fourth quarter: October 1 – December 31

If you are unable to pay the requested co-pay you should tell the pharmacist. The pharmacist cannot refuse to give you services or goods because you are unable to pay the co-pay. (Unpaid co-pays are a debt you owe the pharmacy.)

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

THIS NOTICE ALERTS YOU TO AN IN LIEU OF SERVICE THAT HAS BEEN APPROVED BY THE NEW YORK STATE DEPARTMENT OF HEALTH.

**New York State Medicaid Managed Care
Alternative Services and Settings - In Lieu of Services (ILS)**

New York State, pursuant to federal regulation (42 CFR 438.3(e)), approves cost-effective, medically appropriate, alternatives to regular Medicaid State Plan services included in the Medicaid Managed Care Organization (MMCO) benefit package. These cost-effective alternative services are called "in lieu of services" (ILS).

What you should know about ILS:

- ILS is only available through Medicaid managed care. Medicaid managed care plans can only offer an ILS if they have the State's approval.
- ILS is voluntary. You do not have to use the ILS if you would rather have the regular covered Medicaid service.
- There can be many different types of services offered as ILS.
- ILS may be limited to enrollees who meet certain criteria. For example, the ILS may only be available to people who are a specific age or who live in a certain area.
- ILS may be limited in quantity or duration. For example, you may only be able to get the ILS for 15 days.
- ILS may be limited to a specific setting. For example, you may only be able to get the ILS if you are in a certain type of hospital. Other ILS may only be an option if you are living at home.
- The MMCO may decide to stop offering the ILS. The MMCO will send you a notice if this happens.
- You have the right to a plan appeal and/or State Fair Hearing if you are not happy with a plan decision about your care, including a decision about ILS. See your plan's member handbook for more information about complaints and appeals.

The link below lists ILS that has been approved by New York State.

https://www.health.ny.gov/health_care/managed_care/app_in_lieu_of_svs_mmc.htm

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Welcome to MyHealth PlusSM Health and Recovery Plan

We are glad that you enrolled in MyHealth PlusSM. MyHealth PlusSM is a Health and Recovery Plan, or HARP, approved by New York State. MyHealth PlusSM is a new kind of plan that provides Medicaid members with their health care, plus care for behavioral health. In this handbook, behavioral health means mental health, substance use disorder and rehabilitation.

We are a special health care plan with providers who have a lot of experience treating persons who may need mental health and/or substance use care to stay healthy. We also provide care management services to help you and your health care team to work together to keep you as healthy as possible.

This handbook will be your guide to the full range of health care services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, however, just call Member Services at 1-800-650-4359. You can also visit our website at www.univerahealthcare.com to get more information about the MyHealth PlusSM.

How Health and Recovery Plans Work

The Plan, Our Providers, and You

You may have seen or heard about the changes in health care. Many consumers now get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now these services may be available through MyHealth PlusSM.

As a member of MyHealth PlusSM, you will have all the benefits available in regular Medicaid, plus you can also get specialty services to help you reach your health goals. We offer extended services to help you get and stay healthy, and help with your recovery.

MyHealth PlusSM offers new services, called Behavioral Health Home and Community Based Services (BHHCBS), to members who qualify.

BHHCBS may help you:

- Find housing.
- Live independently.
- Return to school.
- Find a job.
- Get help from people who have been there.
- Manage stress.
- Prevent crises.

As a member of MyHealth PlusSM, you will also have a Health Home Care Manager who will work with all your physical and behavioral health providers to pay special attention to your whole health care needs. The Health Home Care Manager will help make sure you get the medical, behavioral health and social services you may need, such as help to get housing and food assistance.

You may be using your Medicaid card to get a behavioral health service that is now available through MyHealth PlusSM. To find out if a service you already get is now provided by MyHealth PlusSM contact Member Services at 1-800-650-4359.

- You and your health care team will work together to make sure you enjoy the best physical and emotional health possible. You can get special services for healthy living, such as nutrition classes and help to stop smoking.
- MyHealth PlusSM has a contract with New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care, mental health and substance use providers to help us meet your needs. These doctors and specialists, hospitals, clinics, labs, case managers, and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call Member Services at 1-800-650-4359 to get a copy or visit our website at www.univerahealthcare.com.
- When you join MyHealth PlusSM, one of our plan providers will take care of you. Most of the time that person will be your **Primary Care Provider (PCP)**. You may want to choose a PCP from your mental health or substance use clinic. If you need to have a test, see a specialist, or go into the hospital, your Primary Care Provider will arrange it.
- Your Primary Care Provider is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message with how you can be reached. Your Primary Care Provider will get back to you as soon as possible. Even though your Primary Care Provider is your main source for health care, in some cases, you can "self-refer" to certain doctors for some services. See page 11 for details.
- You may be restricted to certain plan providers if you are:
 - getting care from several doctors for the same problem.
 - getting medical care more often than needed.
 - using prescription medicine in a way that may be dangerous to your health.
 - allowing someone other than yourself to use your plan ID card.

Confidentiality

We respect your right to privacy. MyHealth PlusSM recognizes the trust needed between you, your family, your doctors and other care providers. MyHealth PlusSM 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 MyHealth PlusSM, your Primary Care Provider, 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 and other providers who give you care and your authorized representative. MyHealth PlusSM staff have been trained in keeping strict member confidentiality.

How To Use This Handbook

This handbook will tell you how your new health care plan will work and how you can get the most from MyHealth PlusSM. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

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

When you have a question, check this Handbook or call our Member Services at 1-800-650-4359.

You can also call the 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 Fridays
from 8:00 AM - 6 PM or any time you are in crisis**

Call 1-800-650-4359

TTY 1-800-662-1220

- You can call Member Services to get help **anytime you have a question**. You may call us to choose or change your Primary Care Provider (*PCP for short*), to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report that you are pregnant, the birth of a new baby or ask about any change that might affect you or your family's benefits.
- We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that is best for you.
- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with communications devices. Also, we have services like:
 - TTY (1-800-662-1220)
 - Information in Large Print
 - Case Management
 - Help in Making or Getting to Appointments
 - Names and Addresses of providers who specialize in your disability
- **If you are getting care in your home now**, your nurse or attendant may not know you have joined our plan. **Call us right away** to make sure your home care does not stop unexpectedly.

Your Health Plan ID Card

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

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

PART I

First Things You Should Know

How To Choose Your Primary Care Provider (PCP)

You may have already picked your (PCP) Primary Care Provider. **If you have not chosen a PCP, you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you.

Member Services (1-800-650-4359) can check to see if you already have a PCP or help you choose a PCP. **You may also be able to choose a PCP at your behavioral health clinic.**

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

You may want to find a doctor that:

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

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

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

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

You can continue to see your doctor if:

- You are more than 3 months pregnant when you join MyHealth PlusSM and you are getting prenatal care. In that case, you can keep your doctor until after your delivery through post-partum care.
- At the time you join MyHealth PlusSM, you have a life-threatening disease or condition that gets worse with time. In that case, you can ask to keep your provider for up to 60 days.
- At the time you join MyHealth PlusSM, you have been treated for a behavioral health condition. In that case you can ask to keep your provider through treatment for up to 2 years.

At the time you join MyHealth PlusSM, 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. MyHealth PlusSM must tell you about any changes to your home care before the changes take effect.

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

If your **provider leaves** MyHealth PlusSM, we will tell you within 5 days from when we know about this. You may be able to continue to see that provider **if** you are more than 3 months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor through post-partum care. If you are seeing a doctor regularly for a special medical problem, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with MyHealth PlusSM during this time. If any of these conditions apply to you, check with your PCP or call Member Services at 1-800-650-4359.

Health Home Care Management

MyHealth PlusSM is responsible for providing and coordinating your physical health care and your behavioral health services. We use Health Homes to coordinate services for our members. It is your choice if you want to join a Health Home, and we encourage you to join a Health Home for your Care Management.

MyHealth PlusSM can help you enroll with a Health Home that will assign your personal Health Home Care Manager. Your Health Home Care Manager can help you make appointments, help you get social services, and keep track of your progress.

Your Health Home is responsible for giving you an assessment to see what Behavioral Health Home and Community Based Services you may need. Using the assessment, you and your Health Home Care Manager will work together to make a Plan of Care that is designed especially for you.

Your Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your physical and behavioral health care;
- Work with the people you trust, like family members or friends, to help you plan and get your care;
- Support you getting social services, like SNAP (food stamps) and other social service benefits;
- Develop a plan of care with you to help identify your needs and goals;
- Help with appointments with your PCP and other providers;
- Help managing ongoing medical issues like diabetes, asthma, and high blood pressure;
- Help you find services to help with weight loss, healthy eating, exercise and to stop smoking;
- Support you during treatment;
- Identify resources you need that are located in your community;

- Help you with finding or applying for stable housing;
- Help you safely return home after a hospital stay; and
- Make sure you get follow up care, medications and other needed services.

Your Health Home Care Manager will be in touch with you right away to find out what care you need and to help you with appointments. Your Health Home Care Manager or someone from your Health Home provider is available to you 24 hours a day, 7 days a week. Call Member Services at 1-800-650-4359.

If you are in crisis and need to talk to someone right away, call the Crisis Line at 1-800-650-4359.

How To Get Regular Care

Your health care will include regular check-ups for all your health care needs. We provide referrals to hospitals or specialists. We want new members to see his or her Primary Care Provider for a first medical visit soon after enrolling in MyHealth PlusSM. This will give you a chance to talk with your Primary Care Provider about your past health issues, the medicines you take, and any questions that you have.

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

You can call Member Services Monday through Friday twenty-four (24) hours a day, seven (7) days a week at 1-800-650-4359, if you have questions about getting services or if for some reason you cannot reach your Primary Care Provider.

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

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

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

As soon as you choose a PCP, call to make a first appointment. Try to prepare for your first appointment in advance. Your PCP will need to know as much about your medical history as you can tell him or her.

Make a list of your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within four weeks of you joining the plan. Your Health Home Care Manager can help you make and get ready for your first appointment.

For an out-of-network referral, your PCP or plan provider should call Member Services at 1-800-650-4359. The person requesting the approval should include the reasons the request is being made. MyHealth PlusSM will review the information and make a decision within 3 work days of when we have all the information we need, but you will hear from us no later than 7 days after we receive your request. If we need more information to make a decision, we will tell you within 7 days. If it is an urgent request, we will make a decision or tell you we need more information within 3 work days.

- To request to see a specialist outside MyHealth PlusSM network, have your doctor contact Member Services at 1-800-650-4359.
- Sometimes we may not approve an out-of-network referral because we have a provider in MyHealth PlusSM that can treat you. If you think our plan provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You will need to ask for a **Plan Appeal**. See page 28 to find out how.
- Sometimes, we may not approve an out-of-network referral for a specific treatment because you asked for care that is not very different from what you can get from MyHealth PlusSM provider. You can ask us to check if your out-of-network referral for the treatment you want is medically needed. You will need to ask for a **Plan Appeal**. See page 28 to find out how.
- You may access providers in MyHealth PlusSM entire approved network as long as you are referred to an in-network provider by your PCP, other in-network specialist, or by MyHealth PlusSM.
- If you need to see a specialist for ongoing care of a medical or behavioral health condition. Your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.
- *If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:*
 - your specialist to act as your PCP; or
 - a referral to a specialty care center that deals with the treatment of your illness.
- You can also call Member Services for help in getting access to a specialty care center.

Get These Services from MyHealth PlusSM without a Referral

Women's Health Care:

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

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

Family Planning

You can get the following family planning services:

- advice and/or prescription for birth control,
- male and female condoms,
- pregnancy tests,
- sterilization, or an
- abortion.

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

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

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

HIV and STI Screening

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

- You can get an HIV or STI test any time you have an office or clinic visit.
- You can get HIV or STI test any time you have family planning services. You do not need a referral from your PCP (Primary Care Provider). Just make an appointment with
- any family planning providers. If you want an HIV or STI test, but not as part of a family planning service, your PCP can provide or arrange it for you.
- Or, if you'd rather not see one of MyHealth PlusSM providers, you can use your Medicaid card to see a family planning provider outside MyHealth PlusSM. For help in finding either a MyHealth PlusSM provider or a Medicaid provider for family planning services, call Member Services at 1-800-650-4359.
- Everyone should talk to his or her doctor about having an HIV test. To get free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (2437) (English) or 1-800-233-SIDA (7432) (Spanish).

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

HIV Prevention Services

Many HIV prevention services are available to you. We will talk with you about any activities that might put you or others at risk of transmitting HIV or getting sexually transmitted diseases. We can help you learn how to protect yourself. We can also help you get free male and female condoms and clean syringes.

If you are HIV positive, we can help you talk to your partners. We can help you talk to your family and friends and help them understand HIV and AIDS and how to get treatment. If you need help talking about your HIV status with future partners MyHealth PlusSM staff will assist you. We can even help you talk to your children about HIV.

Eye Care

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

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

Behavioral Health – (Mental Health and Substance Use)

We want to help you get the mental health and drug or alcohol abuse services that you may need. If at any time you think you need help with mental health or substance use, you can see behavioral health providers in our network to see what services you may need. This includes services like clinic and detox services.

You do not need a referral from your PCP.

Smoking Cessation

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

Maternal Depression Screening

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

Emergencies

You are always covered for emergencies.

An emergency means a medical or behavioral condition:

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

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

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

Examples of **non-emergencies** are colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. Non-emergencies may also be family issues, a break up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not a reason to go to the emergency room.

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

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

If you are not sure, call your PCP or MyHealth PlusSM.

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

- tell you what to do at home,
- tell you to come to the PCP's office,
- tell you about community services you can get, like 12 step meetings or a shelter,
- tell you to go to the nearest emergency room.

You can also contact MyHealth PlusSM Member Services at 1-800-650-4359 24 hours a day, 7 days a week if you are in crisis or need help with a mental health or drug use situation.

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

- Go to the nearest emergency room or call 911
- Call MyHealth PlusSM as soon as you can (within 48 hours if you can).

Remember:

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

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

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

Urgent Care

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

- This could be 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. If you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at 1-800-650-4359.

Tell the person who answers what is happening. They will tell you what to do.

Care Outside of the United States

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

We Want To Keep You Healthy

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

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

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

PART II

Your Benefits And Plan Procedures

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

Benefits

Health and Recovery Plans provide a number of services you get in addition to those you get with regular Medicaid. We will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services including those you can get from within MyHealth PlusSM provider network and some that you can choose to go to any Medicaid provider of the service.

Services Covered By MyHealth PlusSM

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

Regular Medical Care

- office visits with your PCP
- referrals to specialists
- eye/hearing exams
- help staying on schedule with medicines
- coordination of care and benefits

Preventive Care

- regular check-ups
- access to free needles and syringes
- smoking cessation counseling
- HIV education and risk reduction
- referral to Community Based Organizations (CBO) for supportive care
- smoking cessation care

Maternity Care

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

Infertility Services

If you are unable to get pregnant, Univera Healthcare MyHealth PlusSM covers services that may help.

Starting **October 1, 2019**, Univera Healthcare MyHealth PlusSM will cover some drugs for infertility. This benefit will be limited to coverage for 3 cycles of treatment per lifetime.

Univera Healthcare MyHealth PlusSM will also cover services related to prescribing and monitoring the use of such drugs. The infertility benefit includes:

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

Eligibility

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

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

National Diabetes Prevention Program (NDPP) Services

If you are at risk for developing Type 2 diabetes, Univera Healthcare MyHealth PlusSM covers services that may help.

Starting **February 1, 2020**, Univera Healthcare MyHealth PlusSM will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

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

Eligibility

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

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

And, you meet one of the following criteria:

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

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

Home Health Care

- must be medically needed and arranged by MyHealth PlusSM
- one medically necessary post-partum home health visit, additional visits as medically necessary for high-risk women
- other home health care visits as needed and ordered by your PCP/specialist

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

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

Personal Emergency Response System (PERS)

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

Adult Day Health Care

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

Therapy for Tuberculosis

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

Hospice Care

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

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

Dental Care

MyHealth PlusSM believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex, Inc., an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. *You do not need a referral from your PCP to see a dentist!*

How to Get Dental Services:

Your dental benefits are managed by Healthplex, Inc. who has participating dentists who specialize in general dentistry, pediatric dentistry, oral surgery and gum disease. Your dental care must be provided by dentists in the Healthplex network. You will receive a Healthplex Dentist Directory in the mail.

Healthplex will assign you a participating primary dentist (PCD) based on your address. If you already have a dentist that you want to continue to see, you need to call Healthplex to find out if your dentist is participating with them. If you need to see a dental specialist, your primary dentist (PCD) must make a referral to a dental specialist for you.

- If you need to find a dentist or change your dentist, please call Healthplex at 1-866-795-6493 or please call the MyHealth PlusSM at 1-800-650-4359. Member Services Representatives are there to help you. Many speak your language or have a contract with Language Line Services.
- Show your Member ID card to access dental benefits. You will not receive a separate dental ID card.
- When you visit your dentist, you should show your plan ID card.

You can also go to a dental clinic that is run by an academic dental center without a referral. Please call Healthplex at 1-866-795-6493 for more help.

Vision Care

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

Pharmacy

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

Pharmacy co-pays may be required for some people, for some medications and pharmacy items. There are no co-pays for the following members or services:

- Consumers who are pregnant: during pregnancy and for the two months after the month in which the pregnancy ends.

- Family Planning drugs and supplies like birth control pills, male or female condoms, syringes and needles.
- Consumers in a Comprehensive Medicaid Care Management (CMCM) or Service Coordination Program.
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program.
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI).
- Drugs to treat mental illness (psychotropic) and tuberculosis.

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

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

Hospital Care

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

Emergency Care

- Emergency care services are procedures, treatments or services needed to evaluate or stabilize an emergency.
- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the Emergency Room, in an inpatient hospital room, or in another setting. This is called **Post Stabilization Services**.
- For more about emergency services, see pages 11-12.

Specialty Care

Includes the services of other practitioners, including:

- physical therapist - Limited to 40 visits per calendar year
- occupational and speech therapists – Limited to 20 visits each per calendar year
- audiologist
- midwives
- cardiac rehabilitation
- Podiatry if medically needed

Limits for physical, occupational and speech therapists do not apply if you are under age 21, you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.

To learn more about these services, call Member Services at: 1-800-650-4359.

Residential Health Care Facility Care (Nursing Home)

- includes short term, or rehab stays in a skilled nursing facility;
- must be ordered by your physician and authorized by MyHealth PlusSM;
- covered nursing home services include medical supervision, 24-hour nursing care, assistance with activities of daily living, physical therapy, occupational therapy, and speech-language pathology.

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

Long term (permanent) nursing home stays are not a covered benefit in MyHealth PlusSM (HARP) product. If you qualify for permanent long term placement, you will need to disenroll from MyHealth PlusSM (HARP) Plan. This benefit will be covered by Medicaid fee-for-service until you are enrolled in a Medicaid managed care plan.

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

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

Behavioral Health Care

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

Mental Health Care

- Intensive psychiatric rehab treatment (IPRT)
- Clinic
- Inpatient mental health treatment
- Partial hospital care
- Continuing day treatment

- Personalized Recovery Oriented Services (PROS)
- Assertive Community Treatment Services (ACT)
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services

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

Harm Reduction Services

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

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

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

Behavioral Health Home and Community Based Services (BHHCBS)

BHHCBS can help you with life goals such as employment, school, or other areas of your life you want to work on. To find out if you qualify, a Health Home Care Manager must complete a brief screening with you that will show if you can benefit from these services. If the screening shows you can benefit, the Care Manager will complete a full assessment with you to find out what your whole health needs are including physical, behavioral and rehabilitation services.

BHHCBS includes:

- Psychosocial Rehabilitation (PSR) - helps you improve your skills to reach your goals.
- Community Psychiatric Support and Treatment (CPST) - is a way to get treatment services you need for a short time at a location of your choosing, such as your own home. CPST helps connect you with a licensed treatment program.
- Habilitation Services - helps you learn new skills in order to live independently in the community.
- Family Support and Training - teaches skills to help the people in your life support you in your recovery.

- Short-term Respite - gives you a safe place to go when you need to leave a stressful situation.
- Intensive Respite - helps you stay out of the hospital when you are having a crisis by providing a safe place to stay that can offer you treatment.
- Education Support Services - helps you find ways to return to school to get education and training that will help you get a job.
- Pre-Vocational Services - helps you with skills needed to prepare for employment.
- Transitional Employment Services - gives you support for a short time while trying out different jobs. This includes on-the-job training to strengthen work skills to help keep a job at or above minimum wage.
- Intensive Supported Employment Services - helps you find a job at or above minimum wage and keep it.
- Ongoing Supported Employment Services - helps you keep your job and be successful at it.
- Empowerment Services-Peer Supports - people who have been there help you reach your recovery goals.
- Non-Medical Transportation - transportation to non-medical activities related to a goal in your plan of care

Other Covered Services

- Durable Medical Equipment (DME) / Hearing Aids / Prosthetics / Orthotics
- Court Ordered services
- Case Management
- Social Support Services (help in getting community services)
- FQHC or similar services
- Family Planning

Benefits You Can Get From MyHealth PlusSM Or With Your Medicaid Card

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

Family Planning

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

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

HIV and STI Screening

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

Everyone should talk to his or her doctor about having an HIV test. To access free HIV testing or testing where your name isn't given, call 1-800-541-AIDS (2437) (English) or 1-800-233-SIDA (7432) (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 MyHealth PlusSM does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency and non-emergency medical transportation will be covered through regular Medicaid.

To get non-emergency transportation, you or your provider must call Medical Answering Service (MAS) at 1-866-932-7740. If possible, you or your provider should call MAS at least 3 days before your medical appointment and provide your Medicaid identification number (ex. AB12345C), appointment date and time, address where you are going, and doctor you are seeing.

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

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

Developmental Disabilities

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

Services Not Covered

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

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

You may have to pay for any services that your PCP does not approve. Also, if before you get a service,

you agree to be a "private pay" or "self-pay" patient you will have to pay for the service. This includes:

- non-covered services (listed above),
- unauthorized services,
- services provided by providers not part of MyHealth PlusSM

If You Get a Bill

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

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

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

How Our Providers Are Paid

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

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

Service Authorization And Timeframes

Prior Authorization:

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

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

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

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

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

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

What happens after we get your service authorization request:

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

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**; we 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 service than 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 7 days after we receive your request. We will tell you by the 7th day if we need more information.

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

Timeframes for concurrent review requests:

- **Standard review:** We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 7 days after we received your request. We will tell you by the 7th day if we need more information.
- **Fast track review:** We will make a decision within 1 work day of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within 1 work day if we need more information.

Special timeframes for other requests:

- If you are in the hospital or have just left the hospital and you are asking for home health care, we will make a decision within 72 hours of your request.
- If you are getting inpatient substance use disorder treatment, and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.
- If you are asking for 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 inpatient rehabilitation services after an inpatient hospital admission, we will make a decision within 1 work day of when we have all the information we need, but no later than 7 days after we receive your request. We will tell you by the 7th day if we need more information.
- If you are asking for an outpatient prescription drug we will make a decision within 24 hours of your request.
- A step therapy protocol means we require you to try another drug first, before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision within 24 hours for outpatient prescription drugs. For other drugs we will make a decision within 14 days of your request.

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

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

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

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

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

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

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

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

Other Decisions About Your Care:

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

Timeframes for other decisions about your care:

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

You Can Help With Plan Policies

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

Information From Member Services

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

- A list of names, addresses, and titles of Univera Healthcare's Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about MyHealth PlusSM.
- How we keep your medical records and member information private.
- In writing, we will tell you how MyHealth PlusSM 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 MyHealth PlusSM.

- If you ask us in writing, we will tell you the qualifications needed and how health care providers can apply to be part of MyHealth PlusSM.
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

Keep Us Informed

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

- You change your name, address or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you
- When you enroll in a new case management program or receive case management services in another community based organization

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

Disenrollment and Transfers

1. If YOU Want to Leave MyHealth PlusSM

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

Some examples of good cause include:

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

To change plans:

- Call the Managed Care staff at your local Department of Social Services

- Call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans. The Enrollment Brokers cover Erie County.

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

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

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

2. You Could Become Ineligible for Medicaid Managed Care

- You may have to leave MyHealth PlusSM if you:
 - move out of your County or service area,
 - change to another managed care plan,
 - join an HMO or other insurance plan through work,
 - go to prison,
 - otherwise lose eligibility:

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

3. We Can Ask You to Leave MyHealth PlusSM

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

4. No matter what reason you disenroll, we will prepare a discharge plan for you to help you get services you need.

Plan Appeals

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

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

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

Your provider can ask for reconsideration:

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

You can file a Plan Appeal:

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

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

Aid to Continue while appealing a decision about your care:

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

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

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

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

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling 1-800-650-4359.



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

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

Fax.....315-671-6656

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

In Person..... 205 Park Club Lane, Buffalo, NY 14221

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

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

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

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

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

What happens after we get your Plan Appeal:

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- You can also provide information to be used in making the decision in person or in writing. Call Member Service at 1-800-650-4359 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people

who worked on your first decision.

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

Timeframes for Plan Appeals:

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

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

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

If we need more information to make either a standard or a 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 Member Services at 1-800-650-4359 or writing.

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

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

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

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

If your Plan Appeal results in another denial you may ask for a Fair Hearing. See the Fair Hearing section later in this handbook. If you lose your Plan appeal and Fair Hearing, you may have to pay for the cost of any continued benefits 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 New York State Department of Financial Services. You can call Member Services at 1-800-650-4359, if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the New York State Department of Financial Services: 1-800-400-8882.
- Go to the New York State Department of Financial Services website at: www.dfs.ny.gov
- Call Member Services at 1-800-650-4359.

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

You can get a faster decision if:

- Your doctor can say 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 Internal Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours

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

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

Fair Hearings

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

- You are not happy with a decision your Local Department of Social Services or the State Department of Health made about you staying or leaving MyHealth PlusSM.

- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy about your screening, assessment, or re-assessment for Behavioral Health Home and Community Based Services.
- 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 and an appeal with MyHealth PlusSM. If MyHealth PlusSM agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.
- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
 - reduce, suspend or stop care you were getting; or
 - deny care you wanted;
 - deny payment for care you received; or
 - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

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

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

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

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

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

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

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

When you ask for a Fair Hearing about a decision MyHealth PlusSM made, we must send you a copy of the **evidence packet**. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call 1-800-342-3334 to ask for it.

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

Complaint Process

Complaints:

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

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

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

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

NYS Department of Health
Division of Health Plan Contracting & Oversight
Bureau of Consumer Services
Empire State Plaza, Corning Tower, Room 2019
Albany, NY 12237

You may also contact your local Department of Social Services with your complaint at any time.

You may call the New York State Department of Financial Services (1-800-342-3736) if your complaint involves a billing problem.

How to File a Complaint with Our Plan:

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

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

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

Univera Healthcare
P.O. Box 211256
Eagan, MN 55121

What happens next:

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

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

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

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

After we review your complaint:

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

Complaint Appeals:

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

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

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

Member Rights and Responsibilities

Your Rights:

As a member of MyHealth PlusSM, you have a right to:

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

Your Responsibilities:

As a member of MyHealth PlusSM, you agree to:

- Work with your PCP on your health, ask questions, and agree on the plan of care.
- Work with your care team to protect 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 they know what you want.

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

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

Important Phone Numbers

Your PCP.....	_____
MyHealth PlusSM	
Member Services Department.....	1-800-650-4359
TTY.....	1-800-662-1220
New York State Medicaid Helpline	1-800-541-2831

AfterHours

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

24 Hour Toll-Free Number.....	1-800-650-4359
Your nearest Emergency Room	_____
New York State Department of Health (Complaints).....	1-800-206-8125
NYS Office of Mental Health (OMH): Customer Relations	1-800-597-8481
NYS Office of Alcoholism and Substance Abuse Services (OASAS) Consumer Complaint Line	1-518-457-2020

Local Department of Social Services Addresses and Phone Numbers

Erie County DSS:

95 Franklin St., Buffalo, NY 14202-3959	1-716-858-8000
New York Medicaid Choice	1-800-505-5678
NYS HIV/AIDS Hotline	1-800-541-AIDS (2437)
Spanish.....	1-800-233-SIDA (7432)
TDD	1-800-369-AIDS (2437)
HIV Uninsured Care Programs	1-800-542-AIDS (2437)
TDD.....	1-518-459-0121
Partner Assistance Program	1-800-541-AIDS (2437)
Child Health Plus	1-855-693-6765
Free or low cost health insurance for children	
NYS Growing Up Healthy Hotline	1-800-522-5006
Social Security Administration	1-800-772-1213
NYS Domestic Violence Hotline	1-800-942-6906
Spanish	1-800-942-6908
Hearing Impaired.....	1-800-810-7444
Americans with Disabilities Act (ADA) Information Line	1-800-514-0301
TDD.....	1-800-514-0383

Medical Answering Services (MAS) 1-866-932-7740
Healthplex (Dental Services).....1-866-795-6493
Pharmacy Help Desk 1-800-724-5033
Local Pharmacy: _____

Other Health Providers:

_____	_____
_____	_____
_____	_____

Important Web Sites

MyHealth PlusSM:

<https://www.univerahealthcare.com>

NYS Department of Health:

<https://www.health.ny.gov>

NYS OMH:

<https://www.omh.ny.gov>

NYS OASAS:

<https://www.oasas.ny.gov>

NYS DOH HIV/AIDS Information:

www.health.ny.gov/diseases/aids

NYS HIV Uninsured Care Programs:

<http://www.health.state.ny.us/diseases/aids/resources/adap/index.htm>

HIV Testing Resource Directory:

https://www.health.ny.gov/diseases/aids/general/resources/resource_directory/

NYSOH Marketplace: *<https://nystateofhealth.ny.gov/>*
1-855-355-5777

NOTICE OF PRIVACY PRACTICES

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

OUR COMMITMENT TO YOUR PRIVACY

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

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

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

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

OUR LEGAL DUTY

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

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

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

Uses and Disclosures of Nonpublic Personal Information

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

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

Uses and Disclosures of Medical Information

The following categories describe different purposes for which we use and disclose PHI. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. If we need to use or disclose your PHI in any other way, we will obtain your signed authorization before our use or disclosure. In addition, certain federal and state laws require that we limit how we disclose certain information considered sensitive in nature, such as HIV/AIDS, mental health, substance use disorder, and sexually transmitted diseases. Unless otherwise permitted under applicable laws, we will not disclose such sensitive information without your written consent and will follow more stringent protections where required by law. You may revoke an authorization or consent, referenced above, in writing by completing a cancellation form at any time. This revocation will not affect any actions we took in reliance on your authorization or consent before your cancellation form was processed.

We will not disclose PHI to an unauthorized person not involved in your care or treatment, unless we are required or permitted to do so by law.

Treatment: We may disclose PHI to doctors or hospitals involved in your care. For example, we may disclose your medications to an emergency room physician so that he/she can avoid dangerous drug interactions. This allows providers to manage, coordinate and administer treatment.

Payment: We may use and disclose PHI to collect premiums, to determine our responsibility to pay claims or to notify members and providers of our claim determinations. We may disclose PHI to providers to assist them in their billing and collection efforts. We may also disclose PHI to other insurance companies to coordinate the reimbursement of health insurance benefits. For example, we may disclose PHI to an automobile no-fault insurance company to determine responsibility for claim payment. Also, if you have health insurance through another insurance company, we may disclose PHI to that other health insurance company in order to determine which company holds the responsibility for your claims.

Healthcare Operations: We may use and disclose PHI for purposes of performing our healthcare operations. Our healthcare operations include using PHI to determine premiums, to conduct quality assessment and improvement activities, to engage in care coordination or case management, to determine eligibility for benefits. For example, we may use or disclose PHI when working with accreditation agencies that monitor and evaluate the quality of our benefit programs.

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

To Family and Friends: If you agree or, if you are unable to agree when the situation, (such as medical emergency or disaster relief), indicates that disclosure would be in your best interest, we may disclose PHI to a family member, friend or other person. In an emergency, we will only disclose the minimum amount necessary.

To Our Business Associates: A business associate is defined as someone that assists us in managing our business. For example, a professional that reviews the quality of our products and services. We may disclose PHI to another company that helps us manage our business. For example, we may disclose PHI to a company that performs case reviews to ensure our members receive quality care. These business associates are required to sign a confidentiality agreement with us that limits their use or disclosure of the PHI they receive.

To Plan Sponsors: A plan sponsor is defined as the employer or employee organization that establishes and maintains the employee's benefit plan. If you are enrolled in a group health plan, we may disclose PHI to the plan sponsor to permit the plan sponsor to perform plan administrative functions. For example, the cost analysis of the benefit program. Before PHI is disclosed to your plan sponsor, we will receive certification from the plan sponsor that appropriate amendments have been made to group health plan

document(s) and the plan sponsor agrees to limit their use or disclosure of this information to plan administration functions only.

Research: We may use or disclose PHI for research purposes in limited circumstances. For example, a research project may involve comparing the health and recovery of all members who received one medication to those who received another medication for the same condition. All research projects are required to obtain special approval.

Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release PHI about deceased members to funeral directors for them to carry out their duties.

Organ Donation: If you are an organ donor, we may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, to facilitate organ or tissue donation and transplantation. This may include a living donor as well as a deceased donor.

Public Health and Safety: We may disclose PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. We may disclose PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Victims of Abuse, Neglect or Domestic Violence: We may disclose PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

Required by Law: We may use or disclose PHI when we are required to do so by law. For example, we must disclose PHI to the U.S. Department of Health and Human Services upon request to determine if we are in compliance with federal privacy laws.

Process and Proceedings: We may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose PHI to law enforcement officials.

Law Enforcement: We may disclose PHI to a law enforcement official investigating a suspect, fugitive, material witness, crime victim or missing person. We may disclose PHI of an inmate or other person in lawful custody of a law enforcement official or correctional institution under certain circumstances.

Military and National Security: We may disclose to the military, PHI of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Marketing and Fundraising: To the extent we use PHI for marketing or fundraising purposes, you will be contacted by us and have the right to opt out of receiving these communications from us and our use of your information for such purposes.

Genetic Nondiscrimination Act (GINA): We will not disclose your PHI containing genetic information for underwriting purposes. GINA expressly prohibits the use or disclosure of genetic information for these purposes.

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

Psychotherapy Information: Should it be applicable that your psychotherapy notes be included in an appropriate use or disclosure of information, in most instances, we are required to obtain your authorization for the release of this information.

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

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

Individual Rights

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

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

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

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

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

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

Questions and Complaints

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

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

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

Privacy Rights or Questions:

Contact Office: Customer Care

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

Privacy Complaints:

Contact Office: Corporate Privacy Officer

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

Phone: 1-866-584-2313

E-mail: privacy.officer@univerahealthcare.com



205 Park Club Lane, Buffalo, NY 14421

We Are Here for You

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

TTY: 711

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