Member Handbook

Managed Long-Term Care Program

Anthem

Member Handbook

Managed Long-Term Care Program

855-661-0002 (TTY 711)

anthembluecross.com/nymltc

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Anthem Blue Cross and Blue Shield HP is a culturally diverse company. We welcome all eligible individuals into our healthcare programs, regardless of health status. If you have questions or concerns, please call Member Services at 855-661-0002 (TTY 711) or visit anthembluecross.com/nymltc.

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WELCOME

Welcome to Anthem Blue Cross and Blue Shield HP Managed Long-Term Care (MLTC) plan. We are delighted that you have selected Anthem as your Managed Long-Term Care plan and are confident that you will be very satisfied with your choice. We are a 5-Star rated MLTC plan, according to the New York Department of Health's 2019 Managed Long-Term Care Consumer Guide for NYC. Our plan is especially designed for people who have Medicaid and who need health- and community-based long-term care services like home care and personal care to stay in their homes and communities as long as possible.

How to Use This Handbook

This Handbook provides you with the guidance you need to make the most of your enrollment with Anthem. Here you will find information on the services available to you, how to access these services, your rights and responsibilities as a member of Anthem, and what to do when you have an issue with the care you receive, including filing a complaint or appeal, or initiating disenrollment.

Updates we make to the Member Handbook will be sent to you, and another copy of the Member Handbook can be requested by calling Member Services' Toll-Free Number 855-661-0002 (TTY 711). An electronic copy of the Member Handbook will also be posted on Anthem website.

Please take the time to familiarize yourself with this Handbook and keep it available for future reference. We hope it will be a helpful resource for you.

Help from Member Services

Our members and their care are always at the center of Anthem MLTC plan's focus, and Member Services is a big part of it. We are always happy to provide the help you need to make the most of your enrollment with Anthem.

If you cannot find the information you are looking for in this Handbook or need someone to help explain it for you, please call Member Services. They can explain benefits and services, help you find a provider, schedule a medical appointment, replace a lost ID card, or send you copies of the Member Handbook and/or Provider Directory. Member Services is also glad to discuss any concerns you may have about your care, and they can help you file complaints about your care or a service provider. Additionally, Member Services can explain your rights and responsibilities and help you understand Anthem policies. You may request language translation or other communication assistance when you call.

Member Services is available:

Monday through Friday
8 a.m. to 5 p.m.

Toll Free: 855-661-0002
TTY 711

24/7 NurseLine/After-Hours Assistance
If you have medical questions and cannot reach your primary care provider (PCP) or care manager, or if it is after normal business hours (8:30 a.m. to 5 p.m.), you can always call Anthem and speak directly to a nurse. 24/7 NurseLine, at the same number as Member Services, can give you guidance on healthcare issues, how to deal with a personal crisis in the home, or about whether you should go to the emergency room. Through 24/7 NurseLine, you will have access to all interpreter services described below.

24/7 NurseLine:
855-661-0002 (TTY 711)

Hours of Operations:
24 hours a day, seven days a week

Members Whose Primary Language Is Not English

Anthem is committed to communicating with you in your preferred language. We have employees fluent in several languages and can access outside interpreter services if necessary, free of charge. Anthem ensures you receive the information you need and that your questions and concerns are adequately addressed. If you need member materials and communications in another language, we will make them available to you. We can also help you find providers who speak your language.

Members with Disabilities

Anthem ensures its disabled members receive any necessary assistance to maximize the benefits of their membership.

Physically Disabled Members

Member Services can supply you with information about whether a provider office is wheelchair accessible and find you a provider who can otherwise accommodate your needs. Member Services can also arrange for any needed special transportation arrangements.

Visually Impaired Members

Large print versions of our literature (including this Handbook) are available for members with visual impairment, and some of our materials are available on audiotape or CD. Additionally, our Member Services Representatives are glad to read you the contents of any materials or documents you need help with.

Hearing Impaired Members

Members who are hearing impaired may contact Member Services using our TTY 711.

FOR PROSPECTIVE MEMBERS

Eligibility for Enrollment

You are eligible to join Anthem MLTC program if you meet the following requirements:

- Are age 18 and older
- Reside in an Anthem service area (Bronx, Manhattan, Brooklyn, Queens, Staten Island, Nassau, Suffolk, or Westchester)
- Have Medicaid
- Have Medicaid only or are aged 18-20 with both Medicaid and Medicare **and** are eligible for nursing home level of care
- Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety
- Are expected to require at least one of the following Community Based Long-Term Care Services (CBLTCS) covered by our Plan for a continuous period of more than 120 days from the date of enrollment:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day healthcare
    - Private duty nursing
    - Consumer Directed Personal Assistance Service (CDPAS)

The coverage explained in this Handbook begins on the effective date of your enrollment with Anthem.

Enrollment Process

The enrollment process will determine your eligibility for the MLTC plan and ensure that you are making an informed decision. We take pride in making sure this process is conducted in a manner that is as convenient as possible for prospective members.

Verification of Interest Call

We will contact you by phone to confirm your interest in joining Anthem and to gather information that is relevant to the scheduling of your in-home assessment. We will also answer any questions you might have about the assessment and Anthem MLTC plan at this time.

If necessary, we will transfer you to the New York Independent Assessor (NYIA). You will need an assessment by the NYIA if you are joining an MLTC for the first time, if you have not been in an MLTC plan for forty-five (45) days or longer, or if too much time has elapsed since an earlier CFEEC evaluation. You do not need an NYIA evaluation if you are already receiving Medicaid home care outside of a managed care plan or if you are already enrolled in an MLTC plan and would like to switch to Anthem.

New York Independent Assessor – Initial Assessment Process

The Conflict Free Evaluation and Enrollment Center (CFEEC) has become the New York Independent Assessor (NYIA). The NYIA will manage the initial assessment process, except for expedited initial assessments, which will begin on July 1, 2022. The initial assessment process includes completing the:

- *Community Health Assessment (CHA)*: The CHA is used to see if you need personal care and/or Consumer Assistance Personal Assistance Services (PCS/CDPAS) and are eligible for enrollment in a Managed Long-Term Care plan

- *Clinical Appointment and Practitioner Order (PO)*: The PO documents your clinical appointment and indicates that you:
    - Have a need for help with daily activities, and

- That your medical condition is stable so that you may receive PCS and/or CDPAS in your home

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

Anthem will use the CHA and PO outcomes to determine the level of care and services you need and work with you to create the personal plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care, and any other medical documentation. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to Anthem about whether the plan of care meets your needs.

Anthem Pre-Enrollment Assessment

Once it is determined you are eligible to join a long-term care plan, Anthem will schedule your assessment to establish the most appropriate and effective plan of care for you. This will be conducted by one of our Registered Nurses and will take place within thirty (30) days of your initial contact with Anthem.

At the time of the assessment, the Assessment Nurse will answer questions you or your caregiver may have and make sure that your decision to enroll in Anthem is an informed one. If you decide to enroll, you will complete the enrollment agreement and associated paperwork, and we will let you know when you can expect your enrollment with Anthem to start. The Assessment Nurse will provide you with an Initial Plan of Care outlining the services you need to remain safely at home and in the community. At this time, you will also receive a copy of the Provider Directory, which lists all providers available in the Anthem network.

The choice of Anthem as your Managed Long-Term Care plan is completely voluntary on your part. You can change your mind and withdraw your

application even after you have completed the application process. You can withdraw from the plan orally or in writing until noon of the 20th day of the month preceding the start date of your enrollment. (For example, if you were scheduled to start your membership March 1st, you can withdraw until noon on February 20th.) After this point, you will still be able to leave the plan by requesting disenrollment.

Information about your Anthem benefits and everything you need to know to make the most of your enrollment is provided in this Handbook. We encourage you to review it and keep it for future reference.

FOR ENROLLED MEMBERS

Introduction to Anthem

Welcome to Anthem Blue Cross and Blue Shield HP. We are pleased you chose us as your Managed Long-Term Care Plan (MLTC) and want to ensure you have a beneficial experience with us. Anthem is committed to serving our members in ways that earn trust and loyalty.

Anthem Blue Cross and Blue Shield HP ("Anthem") is a New York State approved Medicaid Managed Long-Term Care Plan operating in the five counties of New York City, as well as Nassau, Suffolk, and Westchester counties. Our program is specifically designed for people like you who are eligible for Medicaid and in need of long-term care services and support, such as home care and personal care. We are committed to helping you stay healthy, safe, and living independently in the community and in the comfort of your own home.

Benefits of Anthem Membership

Dedicated Team Assigned to Your Care

As an Anthem member, you will have a dedicated Care Management Team that includes a Registered Nurse, Social Worker, and Coordinator who will work with you, your healthcare providers, and your loved ones to ensure all your long-term care needs are met. The Team will work with you to determine your needs and design a Person-Centered Service Plan (PCSP) to address them. We also make sure that you and your loved ones understand and agree with the plan for your care and services. Additionally, the Team regularly monitors your services to ensure they are meeting your needs, and we listen to you and your loved ones for any feedback. As your needs change, the Care Management Team is there to make appropriate adjustments to your services. In this way, your Care Management Team is your partner in staying healthy, safe, and independent.

Access to Anthem Network of Providers

Through Anthem, you will have access to a wide array of services that can be tailored to meet your needs: we are your one-stop shop for accessing needed long-term care services. To give you high quality care, we work closely with a wide variety of providers who have chosen to work with Anthem by joining our network. These providers have gone through special training and orientation to participate in our network, and we continually add providers to our network to ensure that our members have adequate choice of providers.

Once enrolled, you will receive a copy of Anthem Provider Directory, which lists all in-network providers. If you do not have one or would like an additional copy, call Member Services' toll free number 855-661-0002 (TTY 711), or visit our website, anthembluecross.com/nymltc.

Coordination with Your Healthcare Providers

Anthem will work with your healthcare providers to help coordinate your long-term care, including hospital and physician services. If you have physician(s) you see regularly, you do not need to make any change; you can continue to get care from them. We are here to help make sure that you receive the care you need, ensuring you have the necessary means to get to your appointments, talking with your healthcare provider(s) to find out how we can support you in your home to manage your medical condition, and staying in communication with them to make sure that your issues and concerns are being addressed timely and appropriately. We strive to make your care seamless for you and your loved ones to manage.

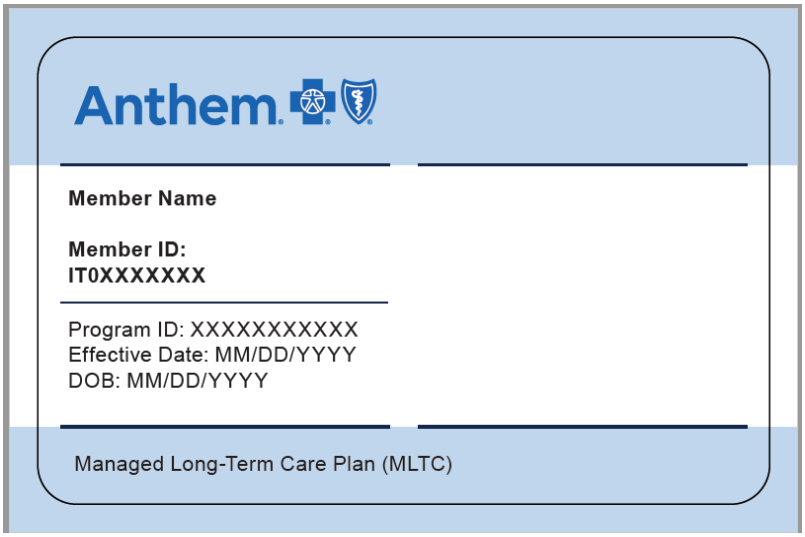
Health Education

Anthem is committed to developing your understanding of the healthcare system and your medical condition(s) and will regularly provide you with patient educational material by mail. Past mailings have addressed subjects such as diabetes management, advance directives, high blood pressure, and immunizations.

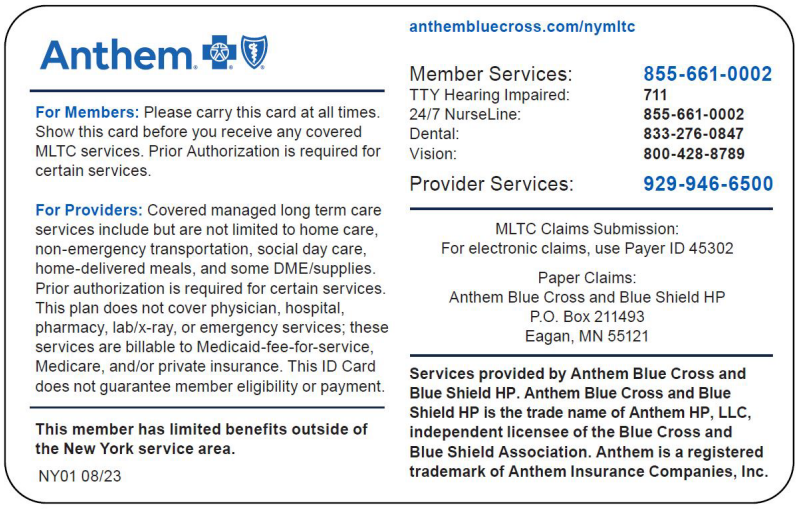
Your Welcome Packet and Anthem ID Card

You will receive a Welcome letter and an Anthem Member ID card within 15 days of your enrollment with Anthem. Your Anthem Member ID Card is stamped with your Member ID number, Medicaid Client Identification Number, and Anthem telephone numbers. Please verify that all information is correct on your card. Be sure to always carry this card with you, as you will need it before receiving care from Anthem network providers. If you lose your member ID card, you can call Member Services' toll-free number 855-661-0002 (TTY 711) to request a replacement card.

Member ID Card- front



Member ID Card- back



Note that when you seek care from your healthcare provider or to obtain services that Anthem does not cover, you will still require your health insurance ID card (Medicare Advantage plan ID, or Medicare and Medicaid benefit cards).

Welcome Letters from Our Dental and Vision Care Partners

During your first month of enrollment with Anthem, you will receive a welcome letter from Liberty Dental Plan, our dental care partner, and Superior Vision, our vision care partner. These will introduce your dental and vision care benefits and detail how to access the services.

If you have questions regarding your vision and dental benefits, you can call the numbers provided in these letters, or you can contact Anthem Member Services' toll-free number at 855-661-0002 (TTY 711).

Your Rights as an Anthem Member

Anthem makes every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Team will arrange for them. Staff will make every effort in assisting you with exercising your rights. Members of Anthem MLTC Plan have the following rights:

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you receive treatment.
- You have the Right to receive information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to receive information in a language you understand, and you can get oral translation services free of charge.
- You have the Right to receive information necessary to give informed consent before the start of treatment.

- You have the Right to be treated with respect and due consideration for your dignity.
- You have the Right to request and receive a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your healthcare, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the Right to get care without regard to sex, including gender identity and status of being transgender, race, health status, color, age, national origin, sexual orientation, marital status, or religion.
- You have the Right to be told where, when, and how to get the services you need from your managed long-term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman program (*See Ombudsman Program section for more information).*

Your Responsibilities as an Anthem Member

It is important that you become familiar with your responsibilities as a member of Anthem, as outlined in this section. As an Anthem member, you are responsible for:

- Maintaining Medicaid eligibility.
- Receiving covered services through Anthem.
- Using Anthem network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for preapproved covered services or in emergencies.
- Being seen by your physician, if a change in your health status occurs.
- Sharing complete and accurate health information with your healthcare providers.
- Helping Anthem keep accurate personal data about you, including changes in name, address, phone number, and additional health insurance carriers.
- Informing Anthem staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Being actively involved in your own care by seeking and obtaining information, by discussing treatment options with your Care Management Team, and by making informed decisions about your long-term care.
- Participating in the development and updating of your care plan.
- Following the plan of care recommended by the Anthem staff (with your input).
- Treating with consideration and courtesy all Anthem personnel and the personnel of any agency or long-term care provider to which you are referred. This includes not discriminating against individuals because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation, or marital status.
- Notifying Anthem within two business days of receiving non-covered or non-preapproved services.

- Notifying your Anthem healthcare team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing Anthem before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Complying with all requirements of Anthem as outlined in your Member Handbook.
- Meeting your financial obligations.

Transfers

If You Want to Transfer to Another MLTC Plan

You can try us for 90 days. You may leave Anthem and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in Anthem for nine months, unless you have a good reason (good cause). Some examples of good cause include:

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Anthem is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the State.

If you qualify, you can change to another type of managed long-term care plan like Medicaid Advantage Plus (MAP) or plans of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. Anthem will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in Anthem.

CARE MANAGEMENT SERVICES

Our goal is to assist you in the management of your health and quality of life so you can be as independent and comfortable as possible in your home. One of the great benefits of enrollment with Anthem is having the knowledge that you need only call one number to arrange for all your medically necessary care and services.

Your Care Management Team

As a member of Anthem, you will have a dedicated team of care management professionals who will be assigned to your care for as long as you are enrolled with us. This team of professionals will work with you, your family, and your healthcare provider(s) to determine your services and develop a care plan tailored to meet your specific needs. Your Care Team will arrange for services and work with health and long-term care providers to coordinate all aspects of your care. A Care Management Team Member will make periodic visits to your home to monitor and assess your care needs to ensure that your care plan is updated as your needs change over time. You will always have access to your Care Team during normal hours of operations and to an on-call Care Manager outside normal business hours.

You will be assigned a Care Manager upon enrollment. We will do our best to match you to the team that can best meet any special needs you might have, including any need to communicate in a language other than English. Your Care Manager will follow up with an outreach call to introduce himself/herself to you and explain how the Care Team will be working with you.

Your Team will include, but is not limited to, a Care Manager (a Registered Nurse), a Service Coordinator, and a Social Worker. The Team is supported by the Assessment Nurse and Care Management Team Manager.

Care Manager

The Care Manager is responsible for coordinating communications between and among you and all the providers responsible for your care. Your Care Manager will:

- Review your medical status, identify and follow up on any issues concerning your long-term care.
- Serve as your primary contact with the agencies providing you services.
- Follow up with your physicians on any medical issues you may have.
- Monitor your medications.
- Counsel and explain your medical issues to both you and your family members and provide education/coaching on how you and your family can help manage your care.
- Contact you monthly to check on your status and progress.
- Update and maintain your case records.

Social Worker

The Social Worker will serve as your primary contact for your behavioral, social, or psychological health services. Your Social Worker will:

- Discuss with you any social, family, psychological, and behavioral issues.
- Serve as primary contact with your behavioral health service providers.
- Identify and help you gain access to community resources.
- Counsel you on social service issues and provide education/coaching to help you and your family to manage your caregiving.

Service Coordinator

The Service Coordinator is the person responsible for setting up your appointments and arranging for any of the in-home services you will receive. Working with your physician, therapists, healthcare providers, and other vendor/agency/service providers, the Service Coordinator will coordinate necessary services in the most efficient way possible to address all of your long-term care needs. Specifically, the Service Coordinator will:

- Assist you in setting up appointments with providers and arranging for in-home services that are part of your long-term care plan.
- Assist in making transportation arrangements for appointments with providers.
- Follow up with providers to assure you receive needed services and to document the care given.
- Provide you with any information you request concerning your care or services.
- Serve as your primary contact with Anthem Member Services Department.
- Make sure that all your records and files are properly maintained.

Person-Centered Service Plan (PCSP)

The Person-Centered Service Plan is a written document detailing the specific type of care and services you will receive to help maintain and improve your health status and keep you as independent as possible. You will participate in the development of the PCSP within fifteen (15) days of enrollment with Anthem. A copy of this PCSP will be sent to you for signature.

The PCSP will be developed by your Care Team and will consider the following:

- The comprehensive set of assessments conducted by NYIA and the Care Team
- Your relevant medical history and current health status/condition
- Consultation with your primary care physician, and, if necessary, any other healthcare providers involved in your care; with your permission
- Input from you, your family, and/or other support networks; with your permission

At Anthem, we are serious about engaging our members in care planning and care management. Your Care Team will consult with you and your family/caregiver or representative when developing the care plan. We consider you to be an important and vital part of the healthcare delivery team. You are encouraged to discuss your healthcare needs with your treating physicians and with your Care Team to ensure that the care plan accurately reflects the services required, incorporates your preferences, and addresses any potential barriers to effective care plan execution.

The Person-Centered Service Plan lists both covered and non-covered services Anthem will be providing and/or coordinating for you. It will detail the type, duration, and frequency of services authorized. Your Care Team will coordinate your services and select appropriate providers, consulting with you during the process to ensure your preferences and/or special needs are

taken into consideration. Your team will also assist in arranging necessary non-covered services and coordinating with appropriate providers.

Care Monitoring, Reassessments, and Care Plan Updates

Your Care Team will be in regular contact with you to find out how you are, assess how the services you are receiving are working, and to discuss any concerns or issues you might have. The Team will closely monitor any medical issues you may be experiencing and work with your healthcare providers and Anthem service providers to ensure that your changing needs are being timely and appropriately addressed.

At times, we may need to visit you at home to conduct assessments so that we can adjust your care plan to provide the right set of services. If you require additional services, different services, or an increase or decrease in the frequency of your current services, the appropriate adjustments will be made with your input. Your Care Team will discuss any proposed changes with you and any other individuals or agencies that will be involved. We will do this as often as necessary, but in no event will we visit you in person less than once every year or contact you by phone less than once a month. As long as you are a member of Anthem, you can count on your Care Team to be on top of your care.

Continuity of Care

Community Based Long-Term Care Services and Supports (CBLTCS)
If you were receiving community-based long-term care services and supports under Medicaid fee-for-service prior to enrollment with Anthem, you will continue to receive these services for either ninety (90) days after enrollment or until an assessment has been completed by Anthem, whichever is later. Community Based Long-Term Care services and supports (CBLTCS) are healthcare and supportive services provided to individuals of

all ages with functional limitations or chronic illnesses that require assistance with daily activities. This includes services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, and Personal Care Services. Included in these services is care such as assistance with bathing, assistance with dressing, help preparing your meals, and assistance with medications.

If you were disenrolled from another Managed Long-term Care Plan due to a service area reduction, closure, or other approved arrangement, you may choose to enroll with Anthem, and we will continue to provide services under your existing plan of care for a continuous period of 120 days after enrollment or until Anthem has conducted an assessment and you agree to the new Person-Centered Service Plan.

If Anthem terminates, reduces, suspends, or otherwise restricts access to these preexisting services, you will receive official notification from Anthem, and will have the right to an internal appeal, fair hearing and external appeal, as well as the right to have the disputed services continued while the request is processed (see *"State Fair Hearings"* and *"State External Appeals"* in *"Actions and Appeals of Actions"* section).

YOUR MANAGED LONG-TERM CARE BENEFITS

Anthem offers a wide range of long-term care and supportive services as part of your covered benefits. You may get the services described below if they are medically necessary, that is, if they are needed to prevent or treat your illness or disability. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your healthcare provider to get these services. Your Care Manager will also work with your healthcare providers to coordinate other "non-covered benefits" such as hospital, physician, or diagnostic services.

What does "Medically Necessary" mean?

A service is deemed "medically necessary" if it is necessary to prevent, diagnose, correct, or cure a condition of yours that causes acute suffering, endangers life, results in illness or infirmity, interferes with your capacity for normal activity, or threatens some significant handicap.

What does "Covered Benefits" mean?

These are benefits and services that are approved through your membership in Anthem, are usually performed or delivered by a network provider, and are paid for by Anthem. The specific services as well as the frequency and duration of these services will be approved based upon your Care Manager's assessment of your medical, physical, and social needs. Anthem will arrange all medically necessary covered services on your behalf.

If at any time, a change is made to the benefits and services covered by Anthem, you will be notified of the change in writing. This notification will be provided at least thirty (30) days in advance of the effective date of such change.

What does "Coordinated Non-Covered Benefits" mean?

These are benefits and services that are **NOT** covered by Anthem. Although coordinated services are not paid for by Anthem, Anthem Care Management staff may assist members to access them. You may choose any provider you like (the provider does not have to be a network provider), as long as that provider accepts Medicare, Medicaid, your third-party insurance, or you pay privately.

Covered and Coordinated Services

Covered Services (Covered by MLTC capitation)	Non-Covered Services (Can be billed Medicaid fee-for-service)
Care Management	Inpatient Hospital Services
Nursing Home Care* (Residential Health Care Facility)	Outpatient Hospital Services
Home Care a. Nursing b. Home Health Aide c. Physical Therapy (PT) d. Occupational Therapy (OT) e. Speech Pathology (SP) f. Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home
Adult Day Healthcare	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME* – including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Nonemergent Transportation	Chronic Renal Dialysis
Podiatry*	Mental Health Services
Dentistry	Alcoholism and Substance Abuse Services
Optometry/Eyeglasses	OPWDD Services
PT, OT, SP or other therapies provided in a setting other than a home	Family Planning Services
Audiology/Hearing Aids*	Prescription and Nonprescription Drugs, Compounded Prescriptions
Respiratory Therapy	Hospice
Nutrition	And all other services listed in Title XIX State Plan
Private Duty Nursing	
Consumer Directed Personal Assistance Services	
Home Delivered or Congregate Meals	
Social Day Care	
Social and Environmental Supports	

*Medicare may cover these services based on certain criteria. If Medicare covers any of these services, then Medicare will be billed first. If you have additional insurance (other than Medicare or Medicaid) that covers any of the above services, this additional insurance will be billed before Anthem. Please always show your Medicaid, Medicare, and Anthem cards when obtaining care or services.

When utilizing any of the above services that are reimbursable by Medicare, you have the freedom to choose your own provider. However, you are encouraged to use Anthem network providers.

Note that the covered services listed can also be delivered by telehealth. Telehealth provides services using electronic information or communications technologies when medically appropriate and when prior authorization for this method of providing care has been obtained.

Descriptions of Covered Services

Adult Day Healthcare	Care provided in a residential healthcare facility that includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, planned leisure time activities, dental, and pharmaceutical services.
Audiology/Hearing Aids	Audiology services include hearing tests and the prescription of hearing aids. Hearing aid services include selecting, fitting and dispensing of hearing aids, as well as necessary maintenance and upkeep of the device. This category also includes the actual hearing aids and associated parts.
Care Management	Process that assists you in accessing necessary covered services as identified in your Person-Centered Service Plan. Care management services include coordination of your services regardless of whether they are in the benefit package.
Consumer Directed Personal Assistance Services	Allows you to receive assistance with personal care services, home health aide services, and skilled nursing tasks from a consumer-directed personal assistant. Please see the "Consumer Directed Personal Assistance Service (CDPAS)" section for greater detail.

Dentistry	Anthem partners with Liberty Dental Plan to provide the following dental services: Diagnostic and Preventive Services, Restorative Dentistry, Root Canal Therapy*, Periodontics, Prosthetics — Crowns and Removable*, Prosthetics — Removable*, Emergency Dental Services*. (*Prior Authorization required, or other limitations may apply.)
Durable Medical Equipment (DME)	This is equipment a healthcare practitioner has determined is necessary for the treatment of your medical condition. Examples include Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries. Prosthetics, Orthotics, and Orthopedic Footwear are **not** durable medical equipment.
Home Care	Services provided in your home, including nursing, home health aide services, medical social services, physical therapy, occupational therapy, and speech pathology therapy.
Home Delivered or Congregate Meals	Meals available for members who cannot prepare or obtain nutritionally adequate meals for themselves.
Medical Social Services	Services by a qualified social worker within the context of your plan of care with the goal of helping you stay in your home.
Nonemergency Medical Transportation	Transportation related to a medical need that is not an emergency. Anthem partners with ModivCare to fulfill your nonemergent transportation needs.
Nursing Home Care (Residential Healthcare Facility)	Nursing Home Care is covered for individuals requiring either short-term care or permanent placement, provided they are eligible for institutional Medicaid coverage.
Nutrition Services	These are services provided by a qualified nutritionist such as the assessment of your nutritional needs, nutrition education, and the planning of your diet.
Occupational Therapy	Rehabilitation services provided by a licensed and registered occupational therapist to address a physical or mental disability and restore you to your best functional level.

Optometry/Eyeglasses	This includes services by an optometrist or an ophthalmic dispenser. Equipment covered by this category includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes, and low vision aids.

Personal Care	Assistance with activities such as personal hygiene, dressing, and eating.
Personal Emergency Response System	This is an electronic alarm device that allows you to easily signal for help in the event of an emergency.
Physical Therapy	Rehabilitation services provided by a licensed and registered physical therapist to help individuals regain or improve their physical abilities
Podiatry	Medical services for your feet provided by a podiatrist.
Private Duty Nursing	Continuous care provided in your home by a registered professional or licensed practical nurse (RN or LPN).
Respiratory Therapy	Services by a qualified respiratory therapist to help with your breathing.
Social and environmental supports	Services such as home maintenance, cleaning, chores, home improvement, as well as respite care.
Social Day Care	Provides functionally impaired individuals with socialization, supervision, and nutrition in a protective setting during any part of the day, but for less than a twenty-four (24) hour period.
Speech Therapy	Treatment by a licensed and registered speech-language pathologist to assist with the rehabilitation of your speaking.

Limitations on Covered Benefits

- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means and to the following conditions:
  - Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube
  - Individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain

inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

- Nursing Home Care is covered for individuals who are in need of short-term care and also long-term care for people considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid.
- Dental care provided through Liberty Dental Plan includes: Diagnostic and Preventive Services, Restorative Dentistry, Root Canal Therapy*, Periodontics, Prosthetics — Crowns and Removable*, Prosthetics — Removable Emergency Dental Services*. (**Prior Authorization required or other limitations may apply.)*

Services that an Anthem member may require that are not covered by Anthem but are billed directly by the Provider to Medicaid, Medicare, or other third-party payer may be included in the member's Plan of Care and coordinated by the Care Team in collaboration with the member's primary care physician and other providers involved in the member's care. Note that Anthem is always the secondary payer to Medicare and other third-party payers. For members with Medicare coverage, if a covered service is paid for by Medicare, Anthem will pay the deductibles, copays, or coinsurances.

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that Anthem does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 855-661-0002 (TTY 711) if you have a question about whether a benefit is covered by Anthem or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription and nonprescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Family Planning

Services Not Covered by Anthem, Medicaid, or Medicare

If medical services are not covered by Anthem, Medicaid, or Medicare, you must pay for them if your provider tells you in advance that these services are not covered AND you agree to pay for them.

Examples of services not covered by Anthem, Medicaid, or Medicare are:

- Cosmetic surgery if not medically necessary
- Personal and Comfort items
- Infertility Treatment
- Provider services that are not part of the plan (unless Anthem sends you to that provider)

If you have any questions, call Member Services at 855-661-0002 (TTY 711).

OBTAINING COVERED SERVICES

During the care planning process, your Care Management Team will work with you, your family/caregiver, and your healthcare providers to determine the services you require. Your Care Manager will then authorize the services you will receive from Anthem, and your Service Coordinator will make referrals to participating Anthem providers and arrange services for you. When a physician order is required, your Care Team will work with your physician and other providers to ensure that the proper order is obtained. We do the work for you to ensure that everything you need is in place.

Requesting Service Authorization

When you ask for approval of a treatment or service, it is called a **service authorization request**. If you feel at any time you need a certain covered service, you or your provider on your behalf may request authorization for the service by making a verbal or written request to your Care Manager, by calling Member Services at 855-661-0002 (TTY 711), or by sending the request in writing to:

Care Management
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

Authorization is the process by which the requested service is determined to be medically necessary by Anthem. Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period.**

Prior Authorization
All covered services require prior authorization (approval in advance) from Anthem except for the following services which members can self-refer for evaluation or for routine services:

- Dental care – routine referrals and services covered under Liberty Dental Plan
- Vision care – routine vision exam and services covered under Superior Vision

Concurrent Review
You can also ask Anthem to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review
Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

After You Request Service Authorization

The plan has a review team to be sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against acceptable medical 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 healthcare 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, a nurse, or a healthcare professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **expedited** process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your request will be handled under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than indicated below.

Time frames for Prior Authorization Requests

Standard Review

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

Expedited Review

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

Time frames for Concurrent Review Requests

When a request is made for an increase in the number or duration of service already being provided, the request is called a **Concurrent Review**.

Standard Review

We will make a decision within one (1) workday of when we have all the information we need, and you will hear from us no later than fourteen (14) days after we received your request.

Expedited Review

We will make a decision within one (1) workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within one (1) workday if we need more information.

Time frames for Extensions

If we need more information to make either a standard or expedited decision about your service request, the time frames above can be extended up to fourteen (14) days. We will:

- Write and tell you what information is needed. If your request is in an expedited 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 as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

You, your provider, or someone representing your interests may also ask us to take more time to make a decision. This may be because you have more information to provide us to help decide your case. This can be done by calling Member Services at 855-661-0002 (TTY 711), or sending the request in writing to:

Care Management
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

You or someone you trust can file a complaint with Anthem if you do not agree with our decision to take more time to review your request. You can also file a complaint about the review time with the New York State Department of Health by calling 866-712-7197.

If our answer is yes to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is no to part or all of what you asked for, we will send you a written notice that explains why we said no. See *"How do I File an Appeal of an Action?"* below for more information on how to make an appeal if you do not agree with our decision.

ACTIONS AND APPEAL OF ACTIONS

What is an Action?

When Anthem denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends, or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required time frames, those are considered plan "actions." An action is subject to appeal. (See *"How do I File an Appeal of an Action?"* below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend, or terminate a

service that is authorized, our letter will be sent at least ten (10) days before we intend to change the service.

Contents of Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take
- Cite the reasons for the action, including the clinical rationale, if any
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process)
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational
- Describe the information, if any, which must be provided by you and/or your provider in order for us to render a decision on appeal

The notice will also tell you about your right to an appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing.
- It will say that you must file an appeal before asking for a Fair Hearing.
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service, the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued, you must ask

for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I file an Appeal of an Action?

If you do not agree with an action that Anthem has taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within sixty (60) business days of the date on our letter notifying you of the action. If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 855-800-4683 (TTY 711), or by writing to:

Appeals and Grievances
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

How do I Request to Continue Service during the Appeal Process?

If you are appealing a restriction, reduction, suspension, or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension, or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see *"How do I File an Appeal of an Action?"* section above.

Although you may request a continuation of services, if the plan appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your case was being reviewed.

How Long Will It Take Anthem to Decide My Appeal of an Action?

Unless your appeal is expedited, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review, you will have a chance to present your case in person and in writing. We will also send you your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or restrict, reduce, suspend, or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires. In some cases, you may request an "expedited" appeal. (See "*Expedited Appeal Process*" Section below.)

Expedited Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of our appeal of the action. We will respond to you with our decision within two business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the time frames under "*How Long Will It Take the Plan to Decide My Appeal of an Action?*" above, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice.

If we are reducing, suspending, or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

Online Request Form: otda.ny.gov/oah/FHReq.asp

Mail a Printable Request Form

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, NY 12201-2023

Fax a Printable Request Form: (518) 473-6735

Request by Telephone

Standard Fair Hearing line: 800-342-3334
Emergency Fair Hearing line: 800-205-0110
TTY line: 711 (request that the operator call 877-502-6155)

Request in Person

New York City
14 Boerum Place, 1st Floor
Brooklyn, NY 11201

Albany
40 North Pearl St., 15th Floor
Albany, NY 12243

For more information on how to request a Fair Hearing, please visit: otda.ny.gov/hearings/request/.

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental/investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental/investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want the external appeal, you must file the form with the New York State Department of Financial Services within four (4) months from the date we denied your appeal.

Your external appeal will be decided within thirty (30) days. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. The reviewer will then tell you and us of the final decision within two (2) business days after the decision is made.

You can get a faster decision if your doctor indicates a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will also be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

ADDRESSING YOUR PROBLEMS AND CONCERNS

Anthem will try its best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Anthem staff or a healthcare provider because you file a complaint or an appeal. We will maintain your privacy. We will give you any help you may need to file a complaint or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may choose someone (like a relative or friend or a provider) to act for you.

To file a complaint or to appeal a plan action, please call Anthem at 855-800-4683 (TTY 711) or write to:

Appeals and Grievances
Anthem Blue Cross and Blue Shield HP
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

When you contact us, you will need to give us your name, address, telephone number, and the details of the problem.

What is a Complaint?

A complaint is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a complaint with us.

The Complaint Process

You may file a complaint orally or in writing with us. The person who receives your complaint will record it, and appropriate plan staff will oversee the review of the complaint. We will send you a letter telling you that we received your complaint and a description of our review process. We will review your complaint and give you a written answer within one of two time frames:

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process will be completed within seven days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

Our answer will describe what we found when we reviewed your complaint and our decision about your complaint.

How do I Appeal a Complaint Decision?

If you are not satisfied with Anthem's decision concerning your complaint, you may request a second review of your issue by filing a complaint appeal. This must be filed within sixty (60) business days of receipt of our initial decision about your complaint. Once Anthem receives your appeal, we will send you a written acknowledgement within 15 business days telling you the name, address, and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including healthcare professionals for complaints involving clinical matters, who were not involved in the initial decision.

For standard appeals, we will make the appeal decision within thirty (30) business days after receiving all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within two (2) business days of receipt of necessary information. For both standard and expedited complaint appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

Ombudsman Program

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long-term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in an MLTC Plan like Anthem. This support includes unbiased health plan choice counseling and general plan related information.

Contact ICAN to learn more about their services:

Toll-free Phone Number: 844-614-8800
TTY Users: call 711 and follow the prompts to dial 844-614-8800
Email: ican@cssny.org

Find out more about ICAN: icannys.org

ACCESS TO PROVIDERS

Transitional Care

If you are transitioning from a Medicaid fee-for-service community based long-term care program, Anthem will continue to provide services authorized under your preexisting service plan and allow you to keep your service providers for a minimum of ninety (90) days. Non-network providers may continue to render the services during this transitional period so long as they accept payment rate offered by Anthem, adhere to Anthem quality assurance and other policies, and provide medical information about the care to Anthem.

If Anthem terminates, reduces, suspends, or otherwise restricts access to these preexisting services, you will receive an official notification from Anthem and will have the right to an internal appeal, fair hearing, and external appeal, as well as the right to have the disputed services continued while the request is processed (*See "State Fair Hearings" and "State External Appeals" in "Actions and Appeals of Actions" section*).

Transitional Care Procedures

New members in Anthem may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network healthcare provider if the provider accepts payment at the plan rate, adheres to Anthem quality assurance and other policies, and provides medical information about the care to the plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Money Follows the Person (MFP)/Open Doors

MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP if you:

- Have lived in a nursing home for three months or longer and
- Have health needs that can be met through services in your community.

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community.
- Finding services offered in the community to help you be independent.
- Visiting or calling you after you move to make sure that you have what you need at home.

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please contact the New York Association on Independent Living:

By phone: 844-545-7108
Email: mfp@health.ny.gov

You can also visit MFP/Open Doors on the web at health.ny.gov/mfp or ilny.org.

Participating Providers in Anthem Network

Covered services are delivered by a network of participating providers. This network is designed to ensure you have adequate choice to meet any special needs you may have. Additionally, all of our providers have contracted with Anthem to ensure quality care for Anthem members. Please refer to the Anthem Provider Directory for a listing of all participating network providers. You may also contact Member Services at 855-661-0002 (TTY 711) if you need another copy of the Directory, or you may access it on our website at **anthembluecross.com/nymltc**. You have the right to select any of the providers participating in Anthem network, and if you find the selection process at all difficult, your Care Team is glad to assist you. The Team's selection will consider factors such as your preferred language, disabilities and special needs you may have, as well as your personal preferences.

We want you to be fully satisfied with all of your service providers. If you are unhappy with one for any reason, you can switch to another participating network provider. Assistance is available from your Care Team.

Payment to our network providers will be made by Anthem for each authorized service they provide you. There is no cost to you. Contact your Care Team if you receive a bill from a provider for any covered services authorized by Anthem, as you are not responsible for it. However, you may be responsible for payment of covered services that were **not** authorized by Anthem or for covered services that are obtained from providers **outside** of Anthem network.

Any services you currently receive that are covered by Medicaid or Medicare that are not covered by Anthem will continue to be covered by Medicare and/or Medicaid fee-for-service. Therefore, it is important for you to carry your Medicare and Medicaid cards in addition to your Anthem ID card.

Veterans' Homes

An Anthem member who is a veteran, the spouse of a veteran, or a Gold Star parent, can access the services of a veterans' home in the network. If there is a veteran's home that is not contracted in the network, but is located in the Anthem service area, arrangements can be made to allow an eligible member to access its services. Consult your Care Manager if you are both eligible and interested.

Dental Provider

Anthem partners with Liberty Dental Plan to administer dental benefits for our members. As an Anthem member, you may access dental services directly without a referral through Liberty Dental Plan's contracted dental providers. Upon enrollment with Anthem, you will be assigned a Primary Care Dentist who is close to your home. If you wish to change your dentist, call Liberty Dental Plan at 833-276-0847 (TTY 711) for assistance.

Vision Provider

Anthem partners with Superior Vision to administer the vision benefits for our members. As an Anthem member, you may access vision services directly without a referral through Superior Vision contracted providers.

Transportation Provider

Anthem partners with ModivCare to administer the nonemergent transportation benefit to our members. As an Anthem member, you may access nonemergent transportation services through a ModivCare contracted transportation vendor. You must provide at least three (3) days' notice for any transportation requests and ten (10) days if you would like to use the MetroCard option for the bus or subway.

To schedule nonemergent transportation:

Call ModivCare: 877-831-3146

"Where's My Ride" line: 877-831-3147 (TTY 866-288-3133)

Out-of-Network Care

If you require a covered service from a nonparticipating provider, Anthem will authorize such service to be provided out-of-network. Such out-of-network authorization will be provided until the services can be provided in-network. One-time authorization may be provided for services such as durable medical equipment, orthotics, prosthetics, or home repair. For services that require continued care such as home healthcare or personal care, authorization will be granted a maximum of ninety (90) days at a time.

Time outside the Service Area

You must inform your care team when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your care team should be contacted to assist you in arranging services.

If you plan to be out of the service area for more than thirty (30) consecutive days, Anthem is required to initiate involuntary disenrollment, as we will not be able to effectively monitor and administer your plan of care. Please contact your care team to discuss your options and to plan transition of your care.

Emergency Care

An emergency is an acute injury or illness that poses an immediate risk to a person's life or long-term health. In the event of any emergency, you should seek immediate care in an emergency room or call 911.

You are not required to obtain prior authorization from Anthem for emergency care, nor do covered services that are medically necessary to stabilize or treat an emergency condition require prior authorization. But in the event of an emergency, you or someone on your behalf should contact your Care Team as soon as possible, and no later than three (3)

days after the emergency.

Your Care Manager will inquire as to the circumstances of your emergency, obtain information from the emergency facility, and determine what additional services, if any, you might need to stabilize your care or prevent similar emergencies in the future. If an adjustment to services is appropriate, your care plan will be revised accordingly.

When Anthem is arranging covered services in an emergency, authorization of service provisions will be for a period of three (3) days. An authorization request must be made in order for the service to continue past three (3) days unless the Care Manager deems continued service medically necessary. If a service is requested by or on behalf of a member during an emergency and there appear to be grounds for urgency, the request will be handled as an expedited request.

Hospitalization

In the event of a hospitalization, you or someone on your behalf should contact Anthem as soon as possible, and no later than twenty-four (24) hours after admission. Your Care Team will cancel or postpone your regularly scheduled services and appointments for the duration of your hospital stay.

Prior to discharge, be sure to ask your hospital discharge planner to contact your Care Team to schedule the resumption of your previous benefits and services and arrange for any new benefits and services you may need upon discharge.

Medicare Covered Services

Membership with Anthem does not affect your Medicare coverage. Your Medicare covered services will continue to be covered by Medicare, and if you are enrolled with a Medicare Advantage Plan, by that plan. You do NOT need to change your healthcare provider or Medicare Advantage Plan if you are enrolled in one. For Medicare services, you do not have to utilize an Anthem participating provider; you may choose any provider you wish. You

do not need to obtain approval from Anthem to receive any Medicare covered benefits. Once your Medicare coverage is exhausted, or a service is NOT covered by Medicare, Anthem will then become the primary carrier for any plan-approved benefits, and you will need to switch to one of our participating providers for that service.

Anthem can assist you with coordination of Medicare services by:

- Arranging Medicare covered home health services
- Arranging nonemergency transportation
- Scheduling appointments for lab work, X-rays, or any other diagnostic tests or services approved by your physician

If you receive benefits or services that are covered both by Medicare and Anthem, Medicare will always be the primary insurance. If Medicare does not cover the entire cost of these services, Anthem may be billed for co-insurance and deductibles.

If you are currently receiving Medicare-covered services or benefits, you may continue to use your current provider for those services. We do, however, recommend that you consider using an Anthem participating provider. This will ensure your services remain covered in the event that Medicare limits or ends your coverage. If your current provider is not an Anthem participating provider, contact your Care Team to discuss your options.

DISENROLLMENT FROM ANTHEM MLTC PLAN

Voluntary Disenrollment

You may request disenrollment from Anthem at any time and for any reason by calling us at 855-661-0002 (TTY 711) or writing to us.

An Anthem representative will ask your reason for disenrollment in order to determine if there is a problem that might be addressed. If you still choose to disenroll, we will send you a confirmation letter acknowledging the receipt of your request for disenrollment. We will also ask you to sign a voluntary disenrollment form. If you are unable or unwilling to sign this, we will proceed with your disenrollment. Anthem will then transmit the disenrollment request with your pertinent information to New York Medicaid Choice (NYMC) or the LDSS for its review and approval.

You should be aware that disenrollment is not immediate. It could take up to six (6) weeks to process, depending on when your request is received.

During the disenrollment process, Anthem will continue to arrange managed long-term care services for you and also coordinate the transfer of your care to the provider you indicate will care for you after your disenrollment.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long-Term Care (CBLTC) services, like personal care, you must join another MLTC plan, Medicaid Managed Care plan, or Home and Community Based Waiver program, in order to receive CBLTC services. *(See "Transfers"* section for limitations on when you can transfer from one MLTC plan to another.)

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by Anthem. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of the involuntary disenrollment reasons listed below.

You will have to leave Anthem if:

- You are no longer eligible for Medicaid benefits.
- You permanently move out of Anthem service area.

- You are out of the service area for more than thirty (30) consecutive days.
- You need nursing home care, but are not eligible for institutional Medicaid.
- You are hospitalized or enter an Office of Mental Health, Office for People with Developmental Disability, or Office of Alcoholism and Substance Abuse Services residential program for forty-five (45) consecutive days or longer.
- You are assessed as no longer having a functional or clinical need for Community Based Long-Term Care (CBLTC) services on a monthly basis.
- You have Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- You are receiving Social Day Care as your only service.
- You no longer require, or receive, at least one CBLTC service in each calendar month.
- At point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTC services.
- You have been incarcerated.
- You provide the plan with false information, otherwise deceive, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

Anthem will also initiate disenrollment in the following situations if, after several attempts to work with you and/or your representative, we determine that the problem cannot be effectively resolved:

- You or your family, or other persons in your home engage in conduct or behavior that prevents Anthem from providing the care you need (not including behaviors that result from your special needs).

- You fail to pay for or make arrangements for the payment of, any spend-down or surplus amount owed to Anthem as determined by the LDSS within thirty (30) days after such amount first becomes due, so long as Anthem makes a reasonable effort to collect beforehand, including making a written demand for payment.

Anthem will not disenroll a member based upon an adverse change in the member's health or due to changes in the capitation rate payable to Anthem. Disenrollment will never be initiated as a result of the member's utilization of covered services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Before being involuntarily disenrolled, Anthem will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. Upon receipt of an approval for disenrollment, Anthem will send a letter to you confirming disenrollment. This letter will state the disenrollment effective date, which will be the first day of the month following the month in which you became ineligible for enrollment. Anthem will continue to provide and arrange for covered services until the effective date of disenrollment and make all necessary referrals for alternative services.

If you continue to need Community Based Long-Term Care services, you will be required to choose another plan or you will be automatically assigned (auto-assigned) to another plan. Involuntarily disenrolled members will be notified of their appeal rights by the LDSS.

Reenrollment with Anthem

If you voluntarily disenroll, you will be allowed to reenroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, you will be allowed to reenroll in the program if the circumstances that were the basis for disenrollment have been resolved.

If you were involuntarily disenrolled due to your failure to make payment of spend-down, you will need to make a full payment of balance due before you can reenroll with Anthem.

All reenrollments are required to be handled as if they were new enrollments. As such, Anthem must reestablish your eligibility for enrollment and conduct a home visit to complete assessments and enrollment application.

ADDITIONAL INFORMATION

Consumer Directed Personal Assistance Services (CDPAS)

Through the Consumer Directed Personal Assistance Service (CDPAS) Program, members can receive partial or total assistance with personal care tasks, home health aide tasks, and/or skilled nursing tasks. The CDPAS assistant performing these tasks is directed, instructed, and supervised by the member. This allows chronically ill and/or physically disabled members greater flexibility and freedom of choice in receiving their home care services. You may exercise the CDPAS option any time during your enrollment with Anthem.

If you opt to use CDPAS, Anthem will continue to be responsible for comprehensive assessment and development of a person-centered service plan. However, you (or your representative) are responsible for making decisions regarding CDPAS staff with respect to recruitment, training, scheduling, evaluation, time sheet verification and approval, and discharge.

To participate in the CDPAS Program, you must obtain a valid Physician's Order and meet all of the following eligibility requirements:

- Have a stable medical condition

- Be self-directing or, if not self-directing, have a designated representative
- Need some or total assistance with one or more personal care tasks, home health aide tasks, or skilled nursing tasks
- Be willing and able to fulfill CDPAS responsibilities (outlined below) or have a designated representative who is willing and able to fulfill such responsibilities
- Participate as needed or have a designated representative who participates as needed, in the required assessment and reassessment processes

Prior to receiving CDPAS, you must sign a consumer acknowledgement of the roles and responsibilities of Anthem and the member which are as follows:

Anthem CDPAS Responsibilities

- Provide you with information on how to qualify for CDPAS and other Community Based Long-Term Care services
- If you express interest in CDPAS, Anthem will provide you with written educational materials outlining the details and associated responsibilities you or your designated representative would need to undertake
- Assess whether you are eligible to receive home care or personal care services
- Determine if you or a designated representative are able and willing to assume all responsibilities associated with receiving CDPAS
- Determine whether you are eligible to receive CDPAS
- Assess your health and document it in the patient centered care plan to ensure adequate supports are available to meet your needs

- Authorize the type, amount, and level of services you require
- Develop a plan of care with you, outlining the tasks to be completed by the personal assistant. The plan of care document will be maintained by Anthem and a copy will be provided to you
- If it is determined that you are no longer eligible to continue receiving CDPAS or if Anthem terminates your receipt of CDPAS, Anthem will assess on an ongoing basis whether you require personal care, home healthcare, or some other level of service
- Provide you with appropriate notices in the event of any termination or reduction in the level and amount of services, including a notice of fair hearing, and, additionally, to provide you with appropriate notice if it is determined that you are ineligible or no longer eligible to receive CDPAS

You or Your Designated Representative's CDPAS Responsibilities

- Review the information provided by Anthem about CDPAS and understand the roles and responsibilities of Anthem, the fiscal intermediary, and you
- Be responsible for recruiting, hiring, training, supervising, scheduling, and terminating the personal assistant(s) of your choosing in order to better meet your needs
- Maintain an appropriate home environment for the safe delivery of care
- Train the personal assistant(s) to implement the plan of care
- Comply with labor laws, providing equal employment opportunities as specified in the agreement between you and the Fiscal Intermediary (FI)
- Inform Anthem and the FI of any change in status or condition, including, but not limited to, hospitalizations, address and telephone number changes, and vacations within five (5) business days

- Assure the accurate and timely submission of the personal assistant's required paperwork to the FI, including time sheets, annual worker health assessments, and required employment documents
- Develop and maintain a contingency plan to ensure adequate supports are available to meet your needs
- Review and sign the personal assistant's weekly timecard to ensure the timecard reflects the actual number of authorized hours worked
- Cooperate with Anthem and agree to comply with Medicaid Managed Care Program requirements, including, but not limited to, availability for required reassessments
- Report and return to Anthem any overpayment or inappropriate payments from the Medicaid program made to Consumer Directed Personal Assistants

In the event you are no longer self-directing, a designated representative will be appointed to assume the above responsibilities for CDPAS. This representative may not act as your CDPAS personal assistant.

If you desire, you may terminate CDPAS and receive Personal Care services through an Anthem network provider. You also may be involuntarily disenrolled from CDPAS if:

- Continued participation in CDPAS would not permit your health, safety, or welfare needs to be met.
- You demonstrate an inability to carry out the required tasks for CDPAS.
- There is evidence of fraudulent use of Medicaid funds in relation to your participation in CDPAS, such as an indication that CDPAS documents have been falsified.

Anthem will review your ongoing eligibility for CDPAS during its semi-annual reassessment and care plan update process. This involves the evaluation of whether you (or your designated representative) have satisfactorily fulfilled

the consumer's responsibilities under the CDPAS Program. If Anthem determines that you are no longer eligible for CDPAS, Anthem will send you (or your designated representative), a timely and adequate notice of our intent to discontinue your participation.

Any restriction, reduction, suspension, or termination of authorized CDPAS services or a denial of any request to change CDPAS participation status is considered an adverse determination by Anthem. This means you may request a fair hearing or external appeal upon the final adverse determination.

Advance Directives

You have a right to make your own healthcare decisions. If this becomes impossible due to an accident or illness, you can still have your decisions exercised so long as you prepare advance directives. Advance directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself.

There are several types of advance directives:

Health Care Proxy

Execution of this document appoints a trusted person (a "proxy") to make healthcare decisions on your behalf should you be unable to do so.

Do Not Resuscitate Order

You have the right to decide if you want emergency treatment such as cardiopulmonary resuscitation (CPR) in the event your breathing or heart stops. If you do not want such treatment, you can make your wishes known in writing through a Do Not Resuscitate (DNR) form. Your primary care physician will then add a DNR to your medical records at your request. You can also get a copy of the DNR form to carry on your person and/or a DNR bracelet that will help ensure emergency healthcare providers are aware of your wishes.

Living Will

A living will allows you to provide specific written instructions regarding your healthcare decision wishes should you become incapacitated.

It is your right to make advance directives as you wish and to determine which type(s) are best for you. You may execute any, all, or none of the advance directives listed above.

For more information regarding advance directives, please speak with your Care Manager or your primary care physician. Consulting a lawyer is not required to execute an advance directive, but you may wish to do so considering the importance of these documents. You can always revise or cancel advance directives at any time should you change your mind. If you already have an advance directive, please share a copy with your Care Manager.

Fraud & Abuse

Anthem is committed to preventing and detecting any fraud or abuse activities by members, providers, staff, or any third parties. Anthem has adopted a "zero tolerance" policy toward fraud and abuse.

If you know or suspect someone is misusing the Medicare or Medicaid program through fraud, abuse, or overpayment, you can report it in the following ways:

1. Calling Anthem Toll-Free Anonymous Compliance Hotline at 833-480-0010.
2. Sending an email to: MLTCComplianceOfficer@anthem.com
3. Writing the Compliance Department Directly at:

Anthem Blue Cross and Blue Shield HP
Attention: Compliance Department
1985 Marcus Ave., Ste. 150
Lake Success, NY 11042

Fraud or misconduct related to the Medicare program will be reported to the Department of Health and Human Services, Office of the Inspector General (HHS-OIG). In the case of suspected fraud or misconduct related to the Medicare Prescription Drug Program, Anthem will file a report with the Medicare Drug Integrity Contractor (MEDIC). Potential fraud, waste, and abuse related to Medicaid and other New York State funded programs will be reported to the New York State Department of Health (NYSDOH) and the Office of the Medicaid Inspector General (OMIG).

All reports filed by you or another on your behalf will be treated confidentially.

Anthem Company Information You May Request

The following information is available to you upon request:

- Information on Anthem structure and operations
- Specific clinical review criteria relating to a particular health condition, and other information that Anthem considers when authorizing services
- Procedures for protecting the confidentiality of medical records and other enrollee information
- A written description of the organizational arrangements and ongoing procedures of the quality assurance and improvement program
- Provider credentialing policies
- A recent copy of Anthem certified financial statement
- Policies & procedures used by Anthem to determine eligibility of a provider

If you are interested in obtaining any one or more of the above items, contact Member Services at 855-661-0002 (TTY 711).

Nondiscrimination Statement

Anthem Blue Cross and Blue Shield HP ("Anthem") complies with applicable Federal civil rights laws and does not discriminate in access to enrollment or provision of services on the basis of race, gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services, place of origin, or with regard to the Capitation rate Anthem will receive.

Anthem will operate in compliance with all applicable state and federal nondiscrimination laws.

Anthem provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as Qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Anthem at 855-661-0002 (TTY 711).

If you believe that Anthem has not provided you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a complaint with Anthem by:

- Mail: Appeals and Grievances
  Anthem Blue Cross and Blue Shield HP
  1985 Marcus Ave., Ste. 150
  Lake Success, NY 11042

- Phone: 855-800-4683 (TTY 711) Monday through Friday
  8 a.m. to 5 p.m. Eastern time

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

- Web: Office for Civil Rights Complaint Portal at
  ocrportal.hhs.gov/ocr/smartscreen/main.jsf
- Mail: Centralized Case Management Operations
  U.S. Department of Health and Human
  Services 200 Independence Ave., SW
  Room 509F, HHH Building
  Washington, D.C. 20201
- Email: OCRComplaint@hhs.gov
- Phone: 800-368-1019 (TTY 800-537-7697)

Cultural Competency

At Anthem Blue Cross and Blue Shield HP, we recognize various ethnic communities and linguistic groups we serve, each with their own cultural traits, linguistic needs, spiritual and health beliefs, practices, and priorities.

The diversity of our community brings opportunities for Anthem, to effectively connect with our diverse member population, and provide services that are culturally and linguistically appropriate and tailored to each member's unique needs.

Key strategies to ensuring the delivery of services in a culturally and linguistically competent manner to all members include:

- Integration of cultural and linguistic understanding into organization policies
- Ensuring that Anthem staff and our network of providers are attuned to meeting the diverse needs of our members
- Providing training and education on culturally and linguistically appropriate service delivery to our staff and our health partners
- Development of culturally and linguistically appropriate marketing and educational materials to meet the literacy levels and language of our membership
- Collaboration with community partners to address health disparities throughout our service area

Our commitment to cultural competency aligns with our mission to make a difference in the lives of the people we serve and is ingrained in everything we do. This commitment keeps the focus on our members and guides our efforts to ensuring that all members, regardless of their country of origin, language, race, ethnicity, cultural background, physical disabilities, differential abilities, sexual orientation, gender identity or expression, are served in a manner that is respectful of, and appropriate to, their social, cultural, and linguistic needs.

To assist in the integration of the knowledge, attitudes, and skills reflective of a culturally competent organization, Anthem maintains a Cultural and Linguistic Competency Plan (CLCP), which reflects a comprehensive, organized, and methodical approach to the strategic planning, development, implementation, and evaluation of cultural competency and

serves as a guide in the ongoing development of a culturally competent service delivery system.

The program utilizes the national Culturally and Linguistically Appropriate Services (CLAS) standards developed by the United States Department of Health and Human Services' Office of Minority Health, as the guide and baseline of standards. Anthem has adopted all 14 National Standards for Cultural and Linguistically Appropriate Services in healthcare to ensure all members who enter the health system receive equal, quality, and effective care.

Multi-Language Interpreter Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 855-661-0002 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-661-0002 (TTY 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 855-661-0002 (TTY 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 5254-225-800 (رقم هاتف الصم والبكم: 855-661-0002).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-661-0002 (TTY 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-661-0002 (телетайп: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 855-661-0002 (TTY 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-661-0002 (ATS 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 855-661-0002 (TTY 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 855-661-0002 (TTY 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 855-661-0002 (TTY 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-661-0002 (TTY 711).

ল◌য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল◌ ◌আছ। ◌ফান করন 855-661-0002 (TTY 711)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 855-661-0002 (TTY 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 855-661-0002 (TTY 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں .855-661-0002 (TTY 711)

Notice of Privacy Practices

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

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

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

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

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

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

- On paper (called physical), we:
  - Lock our offices and files.
  - Destroy paper with health information so others can't get it.
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in.
  - Use special programs to watch our systems.

- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - Teach people who work for us to follow the rules.

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

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

- **For your medical care**
  - To help doctors, hospitals, and others get you the care you need
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit **anthembluecross.com/nymltc** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

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

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

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

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

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**

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

What do we have to do?

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

Contacting you

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

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at 855-661-0002 (TTY 711).

What if you have a complaint?

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

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

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

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **anthembluecross.com/nymltc.**

Race, ethnicity, and language

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

We use this information to:

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

We do not use this information to:

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

Your personal information

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

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

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

anthembluecross.com/nymltc

Services provided by Anthem Blue Cross and Blue Shield HP.

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IMPORTANT CONTACT INFORMATION

For Medical Emergency, Call 911

Anthem Blue Cross and Blue Shield HP MLTC Plan

TTY/TDD Service	711
Member Services	855-661-0002
Appeals & Grievances	855-800-4683

Superior Vision (Vision Services)

Superior Vision Member Services	800-428-8789
Superior Vision Member Services TTY	711

Liberty Dental Plan (Dental Services)

Liberty Dental Plan Member Services	800-276-0847
Liberty Dental Plan Member Services TTY	711

ModivCare (Transportation Services)

ModivCare Customer Service	877-831-3146
"Where's My Ride" Line	877-831-3147
TTY Service	866-288-3133

Other Resources

NYS Managed Long-Term Care Complaint Hotline	866-712-7197
NYS Fair Hearing Section, NYS OTDA	800-342-3334
Department of Financial Services State External Appeals	800-400-8882

855-661-0002 (TTY 711) | anthembluecross.com/nymltc

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