Child Health Plus Member Handbook

November 2018

Welcome To The CDPHP Child Health Plus (CHPlus) Program

Thank you for selecting Capital District Physicians' Health Plan, Inc. (CDPHP®) for your health care coverage. We are glad to have you as a member and are committed to providing you with quality health coverage that's easy to use. This member handbook will help you understand your CHPlus coverage. Please take some time to review it. Although this handbook contains a great deal of information about CDPHP, it is only a brief summary of how to use your benefits. For more details, please refer to your membership contract.

HOW MANAGED CARE WORKS

The Plan, Our Providers, and You

CDPHP has a contract with the State Department of Health to meet the health care needs of children eligible for the CHPlus program. In turn, we choose a group of health care providers to help us meet your child's needs. These doctors and specialists, hospitals, labs and other health care facilities make up our **provider network**. You'll find a list in our provider directory. If you do not have a provider directory, call 1-800-388-2994 to get a copy or visit Find-A-Doc at www.cdphp.com.

If you prefer to do business via the Internet, we offer the convenience of using www.cdphp.com at any time of the day or night. This secure interface enables you to change your PCP, register a change of address, order a new ID card, or check the status of claims.

When you join CDPHP one of our providers will take care of you. That person will be your PCP (Primary Care Provider) and will provide most of your care. If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it. Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or weekends, leave a message with the PCP's answering service and let them how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can self-refer to certain doctors for some services. See page 7 for details.

HOW TO USE THIS HANDBOOK

This member handbook will help you understand your CHPlus coverage. It will tell you how your new health care system will work and how you can get the most from CDPHP. This handbook is your guide to health services and tells you the steps to take to make the plan work for you. Please take some time to review it. Although this handbook contains a great deal of information about CDPHP, it is only a brief summary of how to use your benefits. For more details, please refer to your membership contract.

The first several pages will tell you what you need to know **right away.** The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time. When you have a question, check this handbook or call our Member Services department.

HELP FROM MEMBER SERVICES

If you have any questions about your coverage, please call our Member Services department at (518) 641-3800 or 1-800-388-2994. Member

Services representatives are available Monday through Friday, 8 a.m. to 6 p.m., to assist you. Members may also come to see a Member Services representative at CDPHP, 6 Wellness Way, Latham, NY 12110, between 8:30 a.m. and 4:30 p.m. Please call ahead for an appointment so you will not have to wait. In addition, members can write to us at 6 Wellness Way, Latham, NY 12110 or visit us on the web at www.cdphp.com. Help is available to answer questions and address any concerns you may have. For example, Member Services can explain policies and benefits, accept complaints and appeals, and help resolve bills. If you call after business hours you may leave a message and someone will call you back the next business day.

- **If you do not speak English**, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us at 1-800-388-2994 and we will use an interpreter who speaks your language. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.
- **For people with disabilities:** If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider's office is wheelchair accessible or is equipped with special communications devices. Also, we have services such as:
  - TTY machine (our TTY phone number is 711).
  - Information in large print
  - Case management
  - Help in making or getting to appointments
  - Names and addresses of providers who specialize in your disability

YOUR HEALTH PLAN ID CARD

Your CDPHP ID card should arrive within 14 days after your enrollment date. If anything is wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member.

KEEP US INFORMED

It is important that you notify CDPHP and the NY State of Health, The Official Health Plan Marketplace ("Marketplace") of any of the following changes to ensure your continued eligibility in the Child Health Plus program:

- Changes to your name, address, telephone numbers or email addresses
- Changes in your health insurance coverage
- Changes to your household, such as pregnancy, marriage and changes to your income
- Obtaining other health insurance coverage
- Cancelling your coverage

You can call the Marketplace at 1-855-355-5775 or visit their website at www.nystateofhealth.ny.gov, to make any of these changes.

If you need assistance making any of these changes, CDPHP is here to assist you with Marketplace Facilitated Enrollers. You can reach our Facilitated Enrollers by calling 1-844-237-4773 (TTY: 711), or you can request an appointment by going to https://www.cdphp.com/members/health-plan/government-plans/child-health-plus.

RENEWAL OF COVERAGE

At the end of Your Plan Year, the Marketplace will check to see if you continue to be eligible for coverage under the Child Health Plus Program. The Marketplace will inform you of your eligibility and whether additional information is needed to make this determination. If additional information is needed, you can provide this information by:

PART

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First Things You Should Know

- Calling the Marketplace at 1-855-355-5775.
- Visiting the Marketplace website at nystateofhealth.ny.gov and renew your coverage through your online account.
- Calling CDPHP at 1-844-237-4773 (TTY: 711) and the CDPHP Marketplace Facilitated Enrollers can assist you with providing the additional information and renewing your coverage.

HOW TO CHOOSE YOUR PCP

You may have already picked your PCP (Primary Care Provider) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. **If you have not chosen a PCP for your child(ren), you should do so right away.** If you do not choose a doctor within 30 days, we will choose one for you. Member Services can help you choose a PCP.

Our provider directory is a list of all the doctors, clinics, hospitals, labs, and others who work with CDPHP. It lists the address, phone, and special training of the doctors. The provider directory will show which doctors and providers are taking new patients. You should call their offices to make sure that they are taking new patients at the time you choose a PCP.

You may want to find a doctor:

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

We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs, because the centers have a long history in the neighborhood. Maybe you want to try them, because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or, you can sign up with a primary care physician at one of the FQHCs that we work with, listed in the next column. Just call Member Services at 1-800-388-2994 for help.

Whitney M. Young, Jr. Health Center
Lark & Arbor Drives, Albany, NY
(518) 465-4771

Whitney M. Young Troy Health Center
6 102nd Street, Troy, NY
(518) 833-6900

Hometown Health Centers
1044 State Street, Schenectady, NY
(518) 370-1441

Moreau Family Health Center of Glens Falls
10154 Territorial Park, Fort Edward, NY
(518) 761-6961

If you need to, you can **change your PCP** in the first 30 days after your first appointment with your PCP. After that, you can change up to once every 6 months without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to which your PCP has referred you.

Your doctors generally must all be CDPHP providers. However, in some cases you can continue to see another doctor that you had before you joined CDPHP, even if he or she does not work with our plan. You can continue to see your doctor if:

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

In both cases, however, your doctor must agree to work with CDPHP.

If you have a long-lasting illness or other long term health problems, you may be able to **choose a specialist to act as your PCP (primary care provider).** Your PCP, after speaking with the CDPHP medical director and a specialist, may issue a referral/authorization to a specialist with experience in treating your condition. That specialist will be able to provide and assist with your primary and specialty care. A referral/authorization will be made, along with a treatment plan approved by CDPHP after talking to your PCP, the specialist, and you. The specialist shall be able to treat you without a referral/authorization from your PCP, under the terms of the treatment plan.

If your **provider leaves CDPHP**, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider **if** you are more than three months pregnant or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with the Plan during this time. If any of these conditions apply to you, check with your PCP or call Member Services at (518) 641-3800 or 1-800-388-2994.

As part of your dental benefit, you will have a **Primary Care Dentist, or PCD.** This PCD must be a participating dentist in the network of the dental company CDPHP contracts with. This dental company is called Delta Dental. Delta Dental assigns members to dentists they have seen in the last year, if that dentist participates in our network. If you have not seen a dentist in the last year, and do not make a selection within 30 days of receiving their welcome letter, Delta Dental will assign you a PCD based on your address. You can change your PCD assignment at any time by calling Delta Dental. Your PCD will provide most of your dental care and will refer you to a specialist for dental services when you need one.

If you need to find a dentist or **change your dentist**, please call Delta Dental at 1-800-542-9782 (TTY: 711).

Delta Dental representatives are there to help you. You can also visit www.AllSmilesWelcome.com to find a dentist. Many speak your language or have a contract with interpreter services. You may also call CDPHP Member Services at 1-800-388-2994 with any questions or concerns.

You will receive a separate Delta Dental ID card with the name of your assigned dentist. Show your Dental ID card to access dental benefits.

HOW TO OBTAIN INFORMATION ABOUT PRACTITIONERS

To learn more about our network physicians, go to Find-A-Doc at www.cdphp.com or request a printed provider directory from Member Services. Both sources indicate whether a doctor is board certified. Member Services can also give you more information on a doctor's qualifications.

HOW TO GET REGULAR CARE

Regular care means exams, regular check-ups, shots or other treatments to keep you well, give you advice when you need it, and refer you to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need. Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. As soon as you choose a PCP, call to make a first appointment. If you can,

prepare for your first appointment. Your PCP will need to know as much about your medical history as you can tell him or her. Make a list of your medical background, any problems you have now, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining the plan.

If you need care before your first appointment, call your PCP's office to explain the problem. He or she will give you an earlier appointment. (You should still keep the first appointment.)

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

- Baseline and routine physicals: within 12 weeks,
- Urgent care: within 24 hours,
- Non-urgent sick visits: within 3 days,
- Routine, preventive care: within 4 weeks,
- First pre-natal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd),
- First newborn visit: within 2 weeks of hospital discharge,
- First family planning visit: within 2 weeks,
- Follow-up visit after mental health/ substance abuse or inpatient visit: 5 days,
- Non-urgent mental health or substance abuse visit: 2 weeks.

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

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

HOW TO GET URGENT OR EMERGENCY CARE

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

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

You can get an appointment for an **urgent care** visit for the same or next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call us at (518) 641-3800 or 1-800-388-2994. Tell the person who answers what is happening. They will tell you what to do.

If you believe you have an **emergency**, call 911 or go to the emergency room. You do not need approval from CDPHP or your PCP before getting emergency care, and you are not required to use our hospitals or doctors. If you're not sure, call your PCP or CDPHP. Tell the person you speak with what is happening. Your PCP or member services representative will:

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

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

- Go to the nearest emergency room.

NON-EMERGENCY CARE OUTSIDE THE SERVICE AREA

Non-emergency services delivered outside the CDPHP network are not covered unless they are previously authorized. If you are traveling and have a medical need that is urgent but not an emergency—such as a sore throat or infection—call the CDPHP resource coordination department at 1-800-274-2332. They will advise you and approve needed care. Routine preventive care—such as a checkup—is not covered out of the service area.

CARE OUTSIDE OF THE UNITED STATES

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

HOW TO GET SPECIALTY CARE AND REFERRALS

If you need care that your PCP cannot give, he or she will refer you to a specialist who can. If your PCP refers you to another doctor, we will pay for your care. Most of these specialists are plan providers. Talk with your PCP to be sure you know how referrals work. If you think a specialist does not meet your needs, talk to your PCP. Your PCP can help you if you need to see a different specialist. There are some treatments and services that your PCP must ask CDPHP to approve *before* you can get them. Your PCP will be able to tell you what they are. If you are having trouble getting a referral you think you need, contact Member Services at (518) 641-3800 or 1-800-388-2994.

If we do not have a specialist in CDPHP who can give you the care you need, we will get you the care you need from a specialist outside CDPHP. You will need prior authorization from CDPHP. This is true even if the CDPHP network does not have the right specialist to meet your particular health care needs. To ask for an out-of-plan referral, call CDPHP at (518) 641-4100 or 1-800-274-2332. Your PCP will be contacted and asked to supply a treatment plan explaining why you need an out-of-plan referral. We will assess the treatment plan and consult with your PCP and the out-of-plan provider and make a decision. When a decision is made, you will receive a letter from a CDPHP medical director telling you whether your request has been approved or denied. If it is denied, specific information needed to file an appeal will be explained in the denial letter. If your PCP or CDPHP refers you to a provider outside our network, you are not responsible for any of the costs except any copayments as described in this handbook.

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (a **standing referral**). If you have a standing referral, you will not need a new referral for each time you need care.

If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:

- Your specialist to act as your PCP; or
- A referral to a specialty care center that deals with the treatment of your problem.

GET THESE SERVICES FROM CDPHP CHILD HEALTH PLUS WITHOUT A REFERRAL

Covered Health Care Services That Do Not Require a Referral:

- Office visits, including periodic health examinations when the services are rendered by your Primary Care Provider or designated participating OB/GYN practitioner.
- Emergency room health services.
- Urgent care facility services.
- Reproductive health care when the services are rendered by your designated participating OB/GYN practitioner.
- Emergency, Preventive, and Routine Vision Care when the services are rendered by a network provider.
- Emergency, Preventive and Routine Dental Care.
- Outpatient Acute Mental Health Care Services rendered by a psychologist or social worker that are coordinated by CDPHP. Services rendered by a psychiatrist still require a referral from your Primary Care Provider.

- Outpatient Chemical Abuse and Dependency Treatment Services that are coordinated by CDPHP.

This list highlights key examples of services for which you do not need a referral. Please review your membership contract for the complete list.

WE WANT TO KEEP YOU HEALTHY

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

- Asthma counseling and self-management training,
- Diabetes counseling and self-management training,
- Weight control,
- Stop-smoking classes,
- Cholesterol control,
- Prenatal care and nutrition,
- Breast feeding and baby care.

Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out more and get a list of upcoming classes or visit our website www.cdphp.com.

YOUR RIGHTS

As a member of CDPHP Child Health Plus, you have a right to:

- You have the right to receive information about CDPHP, its services, practitioners/providers, and member rights and responsibilities.
- You have a right to be treated with respect and recognition of your dignity and right to privacy.
- You have a right to participate with practitioners in making decisions about your health care.
- You have a right to a candid discussion of appropriate or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage.
- You have a right to obtain, from a practitioner, complete and current information concerning your diagnosis, treatment, and prognosis, in terms you can reasonably be expected to understand. If appropriate, this information should be made available to another person acting on your behalf.
- You have the right to receive from a practitioner the information you need to give informed consent prior to the start of any procedure or treatment.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- You have the right to formulate advance directives (such as naming a health care proxy form and living will) about your care.
- You have the right to voice complaints, grievances, or appeals about CDPHP or the services it provides.
- You have a right to make recommendations regarding the CDPHP member rights and responsibilities policies.

YOUR RESPONSIBILITIES

As a member of CDPHP Child Health Plus, you agree that:

- You have a responsibility to supply information (to the extent possible) that CDPHP and its practitioners and providers need in order to provide care.
- You have a responsibility to follow plans and instructions for care that you have agreed on with your practitioners.
- You have a responsibility to understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

Member Services (518) 641-3800 or 1-800-388-2994, TTY/TDD 711. This notice is available in other formats for members with special needs or who speak languages other than English. Call the Member Services Department for help.

PART 2

Your Benefits and Plan Procedures

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

SERVICES COVERED BY CDPHP CHILD HEALTH PLUS

You must get these services from the providers who are in CDPHP. All services must be medically necessary and provided or referred by your PCP.

Regular Medical Care

- Office visits with your PCP.
- Eye/hearing exams.

Preventive Care

- Well-child care.
- Well-baby care.
- Regular check-ups.
- Shots for children through childhood.
- Smoking cessation counseling. Enrollees are eligible for 6 sessions in a calendar year.

Specialty Care

Includes the services of other practitioners, including:

- Occupational, physical and speech therapists, audiologists.
- Midwives.
- Cardiac rehabilitation.
- Podiatrists (if you are diabetic).

Hospital Care

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

Emergency Care

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

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

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

Examples of an emergency are:

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

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

Maternity Care

- Pregnancy care.
- Doctors/mid-wife and hospital services.
- Newborn nursery care.

Dental Care

- CDPHP believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Delta Dental, an

expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, X-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

Orthodontics

- This benefit includes procedures which help to restore oral structures to support health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias. Orthodontia coverage is not covered if you do not meet the criteria described above. Prior approval is required for orthodontia services. Please review your subscriber contract for additional details on covered procedures.

Emergency, Preventive and Routine Vision Care

- We will pay for emergency, preventive and routine vision care. This includes vision examinations performed by a participating physician or participating practitioner optometrist for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will pay for one vision examination in any twelve (12) month period, unless required more frequently with the appropriate documentation.

We will pay for:

- Quality standard prescription lenses provided by a participating physician, participating practitioner optometrist, or participating practitioner optician once in any 12-month period, unless required more frequently with appropriate documentation. Prescription lenses may be constructed of either glass or plastic.
- Standard frames adequate to hold lenses once in any 12-month period, unless required more frequently with appropriate documentation. If medically warranted, more than one pair of glasses will be covered.
- Contact lenses—only when deemed medically necessary.

  Coverage for standard prescribed lenses, frames and contact lenses is limited to the amounts listed in your contract. We will not pay more than these amounts for lenses, frames and/or contact lenses. If you would like to purchase a more expensive line of lenses, frames and/or contact lenses, you are responsible for any amounts due above and beyond these amounts.

Prescription Drugs

- Coverage for prescription drugs is subject to the conditions listed in your contract. Please review the contract for details of your prescription coverage. As a highlight, CDPHP only covers medically necessary prescription drugs. Prescriptions must be written by a participating provider, and they must be filled at a participating pharmacy. Coverage is subject to the CDPHP Prescription Drug Formulary that is in effect on the date the prescription is filled. Non prescription drugs which appear on the Medicaid drug formulary are covered.
- The following types of prescription drugs may require prior approval: injectibles, recombinant DNA products, immune-modulating agents, monoclonal antibodies, enteral formulas/modified solid food products, weight loss agents, cosmetic agents used for non-cosmetic medical diagnoses, compounded prescriptions and COX-2 inhibitors. It is your responsibility to obtain prior approval for these drugs.

Failure to obtain prior approval will result in you being responsible for the total cost of the drug. You also may contact the Member Services Department at (518) 641-3800 or 1-800-388-2994 or may consult the CDPHP website at www.cdphp.com to determine at what level, if any, an individual Prescription Drug is covered or if prior approval is required.

Home Health Care (must be medically needed and arranged by CDPHP)

- Up to 40 visits per calendar year by a certified participating Home Health Care agency provider when medically necessary, ordered by your participating provider and approved in writing by a CDPHP medical director as an alternative to hospitalization or treatment in a skilled nursing facility. A care plan must be established in writing and approved by your participating provider and a CDPHP medical director. The medical necessity of Home Health Care Services is determined on a case-by-case basis.

Professional Ambulance Services.

- Pre-Hospital Emergency medical services, including prompt evaluation and treatment of an Emergency condition and/or **non-airborne transportation** to a Hospital.

Inpatient Mental Health Care and Alcohol and Substance Abuse Services

- We will pay for all medically necessary facility, diagnostic and physicians' charges for mental health services, inpatient detoxification and inpatient rehabilitation for alcohol and substance abuse services when such services are provided in a facility that is operated by the Office of Mental Health under sec. 7.17 of the Mental Hygiene Law, issued an operating certificate pursuant to Article 23 or Article 31 of the Mental Hygiene Law, or a general Hospital as defined in Article 28 of the Public Health Law.

Outpatient Mental Health Care and Alcohol and Substance Abuse Services

- Visits may be for family therapy related to mental health care or the alcohol or substance abuse care Outpatient Mental Health Services—You must contact CDPHP or your Primary Care Provider prior to receiving services from a psychologist or social worker. A referral from your Primary Care Provider is still required for services rendered by a psychiatrist. Outpatient Alcohol and Substance Abuse Services—Services must be provided by certified and/or licensed professionals. The services must be ordered by your Primary Care Provider and must be coordinated by CDPHP.

  Please note: Mental and behavioral health benefits and alcohol and substance abuse benefits are performed by CDPHP Behavioral Health. You can call us 24 hours a day, seven days per week, at 1-888-320-9584. TTY/TDD users, call 711.

Autism Spectrum Disorder

- CDPHP will provide coverage for the following services when such services are prescribed or ordered by a licensed physician or a licensed psychologist and are determined by us to be medically necessary for the screening, diagnosis, and treatment of autism spectrum disorder. Autism spectrum disorder means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS). Please review your subscriber contract for more details about this coverage.

EXCLUSIONS FROM COVERAGE

Your contract details the service/items that are excluded from Coverage. Please review the contract language.

If you have any questions, call Member Services at (518) 641-3800 or 1-800-388-2994.

RESOLVING DIFFERENCES— CLAIMS AND APPEALS PROCEDURES

How to File a Complaint

If you do not like some part of your CDPHP coverage that does not involve a decision we have made, you may file a complaint by calling or writing to us. You can ask a designee (such as a lawyer, family member, or trusted friend) to file the complaint or grievance for you.

You can file a verbal complaint:

- To file a complaint by phone, call the Member Services department at (518) 641-3800 or 1-800-388-2994. If we need more information to make a decision, we will tell you.

You can file a written complaint:

- by writing us a letter, or
- by asking us for a complaint form to fill out.

To get a complaint form, call us at (518) 641-3800 or 1-800-388-2994. Mail your complaint (form or letter) to:

CDPHP Attn: Quality Enhancement Department
6 Wellness Way
Latham, NY 12110

Timeframes

Within 15 workdays after we get your complaint we will send you a letter to let you know we are working on it. This letter will include the name, address and telephone number of the individual who will answer your complaint. Qualified personnel will review your complaint, or if it's a medical matter, a licensed, certified, or registered health care professional will look into it.

We also will request any other information we need from you or your practitioner/provider to decide your complaint. If we only get part of that information, we will ask for the missing information, in writing, within five workdays of getting the partial information.

We will give you or your designee a written decision on your complaint within 30 work days after we get your complaint, or within 30 days after we get all needed information, whichever is first. If we do not have all the information we need to decide your case by the 30th workday, we will send you a letter telling you why. We will then make a decision based on the information we have, and inform you of the decision within the next 15 workdays.

If a delay would significantly increase the risk to your health, we will decide your case and tell you our decision by telephone within 48 hours after we get all needed information, or 72 hours after we get your complaint, whichever is first. We will send you written notice of our decision in three workdays.

All written decisions also tell you how to appeal if you wish, and include any forms you need.

Claim (Non-Utilization Review) Determinations

You or your designee may file a claim for benefits, either verbally or in writing, by calling or writing to us. This section does not apply to utilization review determinations.

For utilization review determinations, see the section titled "Utilization Review Decisions."

- Pre-service claims are requests for care, which has not yet been provided to you and needs CDPHP prior approval. We will decide pre-service claim requests within 15 days after we get the request for coverage of services. If we do not have all the needed information to decide by then, we may take up to 15 more days to decide your case. We will send you a letter by the end of the first 15-day period, telling you why we cannot

make a decision. You will be given 45 days from the time we tell you why we cannot make a decision to send us the needed information.

- We will let you know ahead of time of any decision to reduce or end our coverage for ongoing care previously approved by us. We will give you enough time to appeal our decision and get a determination before coverage for the benefit is reduced or ended.
- An urgent (fast) decision can be made in cases where a delay could seriously endanger your life, health, or ability to regain the most function. (We use the "prudent layperson standard" to decide if you meet these criteria.) We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent care claims decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days.

If you ask to extend a course of treatment for urgent care beyond a previously approved period of time or number of treatments, a decision will be made as soon as possible, taking into account your medical needs. You will be told of our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

- If your claim involves care that has already been provided (post-service claims), we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us. All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to file a grievance.

How to File a Grievance

If you do not like a decision CDPHP has made, other than a medical necessity decision, you or your designee may file a grievance by calling or writing to us. This section does not apply to utilization review appeals. See the separate section titled "Utilization Review Appeals."

You have 180 days after we tell you of our decision to file a grievance. To file a grievance by phone, call Member Services at (518) 641-3800 or 1-800-388-2994. If we need more information to make a decision, we will tell you.

You can file a written grievance:

- by writing us a letter, or
- by asking us for a grievance form to fill out.

To get a grievance form, call us at (518) 641-3800 or 1-800-388-2994. Mail your grievance (form or letter) to:

CDPHP Attn: Appeals Department
6 Wellness Way
Latham, NY 12110.

After we get your grievance, we will send you a letter within 15 workdays. We will tell you the name, address, and telephone number of the person who is working on your grievance. We also will request any other information we need from you or your practitioner/provider to make a grievance determination. If we only get part of that information, we will ask for the missing information, in writing, within five workdays of getting the partial information.

If your case is a medical matter, a clinical peer reviewer who did not make the first decision will look at it. If your case is not medical, a qualified person who is at a higher level than the person who made the first decision will look at it.

If your grievance involves pre-service claims (request for care not yet given) we will decide it within 15 days after we get it.

If your grievance involves urgent care claims, and a fast decision is needed, we will decide it as soon as possible, taking your medical needs into account, but no later than 48 hours after we get your grievance. We will tell you of our decision with written or electronic notice to follow within three days.

If your grievance involves post-service claims (care given in the past) we will decide it within 30 days from when we get your grievance.

All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

Appeals

If you are not satisfied with how we decide your complaint or grievance, you have 60 workdays after hearing from us to file an appeal. You can do this yourself or ask a designee to file the appeal for you. The appeal may be in writing or by phone. You can call, write a letter, or use the CDPHP complaint form.

Send your appeal letter or form to:

CDPHP, Attn: Appeals Department
6 Wellness Way
Latham, NY 12110

Or call Member Services at (518) 641-3800 or 1-800-388-2994 for help.

We will send you a letter within 15 working days. The letter will tell you the name, address, and telephone number of the person who is working on your appeal. It will also tell you if we need more information. Your appeal will be decided by:

- Qualified health care professionals, at least one of whom is a clinical peer reviewer who did not work on your original complaint or grievance, if your appeal involves a medical matter; or
- If your appeal is not about medical matters, people who work at a higher level than those who decided your original complaint or grievance.

When a delay would risk your health, we will let you know our decision within 48 hours after we get the information we need, or within 72 hours after we get your appeal, whichever is first. We will send you written notice of our decision within three working days.

For all other appeals, CDPHP will decide within 15 days of getting an appeal for pre-service claims and within 30 days of getting post-service claims. All decisions will tell you the specific reasons for the decision, any medical reasons for the decision, and how to appeal the decision.

Utilization Management Decisions

CDPHP has a utilization review (UM) team made up of doctors and nurses. Qualified health care professionals make all UM decisions. If you disagree with a UM decision, our resource coordination department (1-800-274-2332) may be able to help. You, a designee, or your doctor may question any utilization review decision.

Prior Approvals and Prospective Review

You or your doctor must contact the CDPHP resource coordination department to get prior approval for certain covered treatments.

For pre-service claims, decisions are made in three work days after we get the needed information, or 15 days after we receive a request for services, whichever comes first. If we do not have all the information we need by the 15th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 15-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you receive our request to provide the information to us. We will let you or your designee, and your doctor know our decision by telephone and in writing.

Concurrent Review

If you have been getting care or treatment that should be continued, or if more services are needed, we will review the request and make our decision within one work day after we get the information we need, or 15 days after your first request, whichever is first. We will let you or your designee and your doctor know our decision by telephone and in writing. We will let you know of any decision to reduce or end our coverage for ongoing care approved by us earlier. We will give you enough time to appeal our decision and get a decision before coverage for the benefit is reduced or ended.

Retrospective Review

If we are checking on **care that has been given in the past,** we will decide within 30 days from when we receive your request. If we do not have all the information we need by the 30th day, we may take up to 15 more days to decide your case. We will tell you before the end of the first 30-day period what other information we need and the date by which we expect to decide. We will give you 45 days from the time you get our request to provide the information to us.

Urgent Review

An urgent (fast) decision can be made in some prior approval, prospective review, and concurrent review cases. We will make a fast decision when waiting for the above time frames could seriously endanger your life, health, or ability to regain the most function. We use a "prudent layperson standard" to decide if you meet these criteria. We will also make a fast decision if your doctor believes you would suffer severe pain without the requested care or treatment. Urgent decisions are not available for retrospective reviews.

Urgent care utilization review decisions are made as soon as possible, taking your medical needs into account, but no later than 72 hours after we receive your request. We will tell you of the decision by telephone with written or electronic notice to follow within three days. If you ask to extend a course of treatment for urgent care beyond the approved period of time or number of treatments, a decision will be made as soon as possible, taking your medical needs into account. We will tell you our decision within 24 hours after we get your request, if your request is made at least 24 hours before your course of treatment is scheduled to end.

Reconsideration of Reviews

If we make a decision without speaking to your doctor, your doctor may ask to speak to a CDPHP medical director. This option does not apply to a retrospective review. The medical director will talk to your doctor and make a decision within one workday.

Notice of Appeal Rights

All notices of decisions from CDPHP are in writing and include detailed reasons for the decision, including the medical rationale and the section of your contract upon which the decision was based.

Your options for asking for an appeal from us or the State will be explained. If you request, you may also receive, free of charge, reasonable access to or copies of all documents about your case.

If CDPHP fails to make a utilization review decision within the above time frames, this can be considered the same thing as a denial, which would then be subject to appeal.

Utilization Review Appeals

You or your designee can appeal a utilization review (UR) decision. Just call Member Services at (518) 641-3800 or 1-800-388-2994 to appeal any CDPHP utilization review decision. In the case of past care reviews, your doctor can also make the appeal. There are two kinds of UR appeals: fast track and standard.

Use the **fast track** UR appeals process when:

- you need an OK to continue current health care, or
- you need more services added to those you are getting, or
- your doctor thinks our plan should look at the request again right away, or
- a delay could seriously put your life, health, or ability to regain the most function in danger (based on the "prudent layperson standard"), or
- your doctor believes you would suffer severe pain without the requested care or treatment.

We will decide fast track UR appeals within two work days after we get the information we need, or within 72 hours after we get your appeal, whichever is first. If we need more information to decide your case, we will immediately tell you and your practitioner/provider by telephone and in writing of what we need. A clinical peer reviewer will be available to talk with you or your designee within one workday after we get notice of the UR appeal. The decision on your appeal will not be made by the same reviewer who decided it the first time.

We will follow up with written notice to you within 24 hours after our decision. The notice will tell you the specific reasons for our decision, including the medical reason, and all options for appeal. If we deny your fast track UR appeal, you can request a standard UR appeal or an external appeal.

In all other cases (non-fast track), if you, your designee, or your doctor do not agree with what we decided, you may appeal using the **standard** UR **appeals** process.

- You must file a standard UR appeal (by phone or in writing) within 180 days of getting notice of our decision (which will tell you how to appeal).
- Within five workdays, we will send you a letter telling you the name, address, and telephone number of the person who is working on your appeal.
- The decision on your appeal will not be made by the same reviewer who decided the first time.

If we need any additional information to decide your UR appeal, we will send you or your practitioner/provider a letter within five days after we get your UR appeal.

- We will decide your UR appeal and let you know within 30 days.
- If we deny your UR appeal, we will tell you why in writing. We will also tell you how you can make further appeals.
- If we do not make a fast track or standard decision within the above time frames, we must allow you to get the service you or your doctor asked for.

In some cases, you can ask to skip the UR appeal step and go directly to an external appeal. If we agree to an external appeal, we will send you a letter within 24 hours. See the following section.

External Appeals

You may ask for an external appeal if one of the three conditions below is met:

1. CDPHP turned down your request for service, saying that it was not medically necessary. The service must otherwise be covered under your contract;
2. CDPHP denied coverage for a health care service because we believe it is experimental or investigational; or
3. CDPHP turned down your request for a service, on the grounds that the requested health service is out-of-network and an alternate recommended health service is available in-network.

With respect to #2 above, the following must also be true:

- Your doctor tells us that you have a life-threatening or disabling condition or

disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate or (b) for which there does not exist a more beneficial standard health service or procedure covered by CDPHP, or (c) for which there exists a clinical trial or rare disease treatment.

- A "life-threatening condition or disease" is one that your doctor believes has a high probability of death. A "disabling condition or disease" is a health issue that can be expected to result in death, last for a year or more, or keep you from working and/or doing any age-appropriate substantial, gainful activities.
- Your doctor has:
  a. recommended a service or pharmaceutical product (as described in New York Public Health Law § 4900(5)(b)(B)) that is more likely to help you than any covered care. He or she must base the request on two acceptable documents from available medical and scientific evidence. Only certain documents will be considered. Your doctor should contact the State Insurance Department to find out more; or
  b. in the case of a rare disease, provided a certification (as described in New York Public Health Law § 4900(7-g)) that the requested health service or procedure is likely to benefit you in the treatment of your rare disease and that the benefit to you outweighs the risk of the service or procedure; or
  c. recommended a clinical trial for which you are eligible (only certain clinical trials are covered).
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.
- The care your doctor recommends would be covered under your contract if we had not decided it was experimental or investigational.

With respect to #3 above, the following must also be true:

- Your doctor has:
  a. certified that the out-of-network health service is materially different than the alternate recommended in-network service; and
  b. recommended a health care service that, based on two acceptable documents from the available medical and scientific evidence, is likely to be more clinically beneficial than the alternate recommended in-network treatment and the adverse risk of the requested health service would likely not be substantially increased over the alternate recommended in-network health service.
- Your doctor must be licensed and board-certified or board-eligible in the specialty needed for your condition.

If you wish, you and CDPHP may agree in writing to waive the UR appeal step and go directly to an external appeal.

All external appeals will be conducted by agents who are certified by the Commissioner of the New York State Department of Health. These agents are randomly assigned to conduct external appeals.

You or your designee has four months after getting an adverse UR appeal decision from CDPHP to ask for external appeal. Your designee may file for it on your behalf. Or, if it is a situation where the care has already been delivered, your doctor may file for the external appeal.

If you and CDPHP agree in writing to waive the UR appeal step, you have four months after filing the waiver to submit a written request for an external appeal.

External appeal requests must be in writing on a standard New York State Department of Financial Services (DFS) form. CDPHP will give you a copy of this form with our UR appeal decision or our written waiver of that step. Or, you can ask for a form by calling CDPHP at (518) 641-3800 or 1-800-388-2994 or DFS at 1-800-400-8882. It is also available online at www.dfs.ny.gov or www.health.ny.gov.

Having an external appeal means you give up your rights to complete the rest of the CDPHP grievance process (hearing and board of directors review).

You, your designee, and your doctor may submit supporting documents to the external appeal agent during the same four-month period. If these documents contain new information that is different from the facts CDPHP used to make its UR appeal decision, CDPHP may take up to three work days to consider the new facts and review its decision.

The external appeal agent will decide your appeal within 30 days of getting it. During that time, he or she may request information from you, your designee, your doctor, and CDPHP. If the agent asks for more information, he or she may take up to five extra workdays to decide your case. The agent will notify you and CDPHP, in writing, of the decision within two workdays after the decision is made.

However, if your doctor says that a delay could be an imminent or serious threat to your health, the decision will be made within three days of the request. The agent will notify you and CDPHP of the decision right away, either by phone or fax. A written copy of the decision will also be sent right away.

If the external appeal goes in your favor, CDPHP will cover the care in question, subject to the terms of your contract. If the agent agrees that you should be allowed to enter a clinical trial, CDPHP will only cover the costs of your treatment within the trial. CDPHP will not cover investigational drugs or devices that are part of the clinical trial. We also will not cover costs of the clinical trial that would not be covered under your contract, such as for research or non-health-related items.

It is YOUR RESPONSIBILITY to initiate the external appeal process. You can file an external appeal by sending a completed form to DFS. If you already received the service in question, your doctor may file an external appeal for you, but you would need to agree to this in writing.

Under New York State law, a completed request for appeal must be filed within four months of either the date upon which you get written notification from us that we have upheld a denial of coverage or the date upon which you get a written waiver of the utilization review appeal step. We have no authority to grant an extension of this deadline.

CDPHP Grievance Committee Hearing

If you do not agree with the decision made through our appeal processes, you or your designee may ask for a hearing before the CDPHP grievance committee. This option is not available if you have an external review. You must ask us for a hearing (verbal or written) within 60 workdays after we tell you of our appeal decision.

The grievance committee is made up of individuals not previously involved in any of our prior decisions in your case.

We will send you a letter within five workdays after we get your request for a hearing. The letter will include the name, address, and telephone number of the person who will answer the hearing request, as well as any additional information needed.

A hearing will be held within 45 days after you make your request. The hearing will be led by the chairperson of the CDPHP grievance committee or his or her designee, and will be recorded by a court stenographer. You can

appear before the grievance committee, or to participate by telephone or other appropriate technology. You may also choose a person to represent you at the hearing.

The CDPHP grievance committee will send you or your representative a letter with its decision within five workdays after the hearing. The letter will include the grievance committee's decision and how you can appeal if you don't agree with the decision.

If a delay would considerably increase the risk to your health, we will make sure that the hearing is held and you get the decision within 48 hours after we get all the needed information, or 72 hours after you asked for a hearing, whichever is first, with a letter sent to you within three work days after the decision.

Board of Directors

If you do not agree with the decision made by the CDPHP grievance committee, you can ask that the CDPHP board of directors review the decision. You must ask in writing within 30 days of when you get the CDPHP grievance committee decision. After we get your letter, the board of directors will review your request at its next regularly scheduled meeting. The CDPHP board of directors will only consider the full record of the CDPHP grievance committee hearing. The board of directors will provide you or your designee a written decision within 30 days of its meeting.

Complaints to New York State

If you are unable to resolve a problem with CDPHP, you may also file a complaint anytime by contacting:

New York State Department of Health
Corning Tower Room 2019
Empire State Plaza
Albany, NY 12237
1-800-206-8125
www.health.ny.gov

or

New York State Department of
Financial Services
One Commerce Plaza
Albany, NY 12257
1-800-342-3736
http://www.dfs.ny.gov

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of health care services. You can call Member Services at (518) 641-3800 or 1-800-388-2994 if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways.

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

FILING A CLAIM

Even though you should not be billed for services covered through CDPHP, if you do receive covered services and pay for them out of your own pocket, you may file a claim with us to be reimbursed. Please send the itemized bill and a receipt to: CDPHP, 6 Wellness Way, Latham, NY 12110. Claims should be sent within 90 days of receiving care.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members. If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at (518) 641-3800 or 1-800-388-2994 to find out how you can help.

INFORMATION FROM MEMBER SERVICES

Here is information you can get by calling Member Services at (518) 641-3800 or 1-800-388-2994.

- A list of names, addresses, and titles of the CDPHP Board of Directors, Officers, Controlling Parties, Owners and Partners.
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses.
- A copy of the most recent individual direct pay subscriber contract.
- Information from the Department of Financial Services about consumer complaints about CDPHP
- How we keep your medical records and member information private.
- In writing, we will tell you how CDPHP checks on the quality of care to our members.
- We will tell you which hospitals our health providers work with.
- If you ask us, we will tell you the guidelines we use to review conditions or diseases that are covered by CDPHP.
- If you ask, we will tell you the qualifications needed and how health care providers can apply to be part of CDPHP.
- If you ask, we will tell you: 1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services, and, if so, 2) information on the type of incentive arrangements used; and 3) whether stop loss protection is provided for physicians and physicians groups.
- Information about how our company is organized and how it works.

TERMINATION OF YOUR CONTRACT

Described below are reasons why your Contract may terminate.

Default in Payment of Premiums. If you are required to pay all or a portion of your premium under your Contract, your Contract will automatically terminate as of the date to which your premium has been paid if we do not receive the premium by the *end of the grace period*. If the premium is not paid by the *end of the grace period*, you will not be entitled to any service under your Contract given to you after the date to which your premium has been paid. If you receive care from a CDPHP physician following the date your Contract terminates, the adult must pay the CDPHP physician at his or her normal charges. However, if you are totally disabled on the date your Contract terminates you will continue to be entitled to service covered under your Contract for the condition, which caused the disability (See Benefits After Termination on the next page).

If You No Longer Qualify. If you no longer meet the Child Health Plus eligibility requirements your coverage will end. You will no longer be eligible for Child Health Plus: on the last day of the month in which you reach the age of 19; or the date on which you are enrolled in the Medicaid program; or the date on which you become covered under other health coverage. Your Contract will terminate on the first day of the month following any event that results in your no longer meeting the Child Health Plus eligibility requirements.

We will require you or the adult to provide documentation each year to certify that you still meet the Child Health Plus eligibility

requirements. Failure to provide the requested documentation may result in termination of your contract.

When the State Child Health Plus Program Terminates. Your Contract will terminate on the date when the State law that establishes and provides funding for the Child Health Plus Program is terminated, or on the date our participation in the Child Health Plus Program terminates.

Your Option to Terminate Your Contract. You or the adult may terminate your Contract at any time by giving us at least 30 days prior written notice. If your Contract is terminated in this manner we will refund any portion of the premiums for the Contract, which have been prepaid.

Our Option to Terminate Your Contract. We may terminate your Contract for any of the following reasons:

A. If we discontinue the entire class of contract to which your Contract belongs. In other words, we may terminate the Contract if we also terminate the same contract held by everyone else. We will give you or the adult at least 5 months written notice that your Contract will be terminated in this manner.

B. We may terminate your Contract for any reason approved by the Superintendent of Insurance. If your Contract is terminated in this manner, a copy of the reason will be provided to you upon request. We will give you or the adult at least 30 days written notice that your Contract will be terminated in this manner.

C. We may terminate your Contract for fraud committed by you when you applied for your Contract or when you filed any claim under your Contract.

D. If you move outside of the State you will no longer be eligible to participate in the Child Health Plus program and your Contract will be terminated.

E. If you move outside our Service Area, your Contract will terminate. Our Service Area is the counties of Albany, Broome, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington in the State of New York.

Benefits After Termination. If you are, in our sole judgment, totally disabled on the date this Contract terminates, and you have received service or care for the illness, condition, or injury that caused your total disability while you were covered under this Contract, we will continue to provide care relating to the total disability covered under this Contract during an uninterrupted period of total disability until the first of the following dates:

A. A date you are, in our sole judgment, no longer totally disabled.

B. A date 12 months from the date this Contract terminates.

However, we will not pay for more care than you would have been entitled to receive if your coverage under this Contract had not terminated.

IMPORTANT PHONE NUMBERS

Your PCP	
THE PLAN	www.cdphp.com
Member Services	(518) 641-3800 or 1-800-388-2994
Member Services TTY/TDD	711
Resource Coordination	(518) 641-4100 or 1-800-274-2332
CDPHP Behavioral Health Services	1-888-320-9584
CDPHP Behavioral Health Services TTY/TDD	711
Your nearest Emergency Room	
New York State Department of Health (Complaints)	1 800-206-8125
New York Health Options	1-855-693-6765
Local Pharmacy	
Other Health Providers:	

Member Services (518) 641-3800 or 1-800-388-2994, TTY/TDD 711. This notice is available in other formats for members with special needs or who speak languages other than English. Call the Member Services Department for help.