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Elderplan Plus Long-Term Care (HMO D-SNP)

Medicaid Handbook

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Medicaid Member Handbook

SECTION 1. Welcome to Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program

Welcome to Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program. The Medicaid Advantage Plus Program is especially designed for people who have Medicare and Medicaid and who need health and long- term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits Elderplan Plus Long-Term Care (HMO D-SNP) covers since you are enrolled in the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program. It also tells you how to request a service, file a complaint or dis-enroll from Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program. The benefits described in this handbook are in addition to the Medicare benefits described in the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage. Keep this handbook with the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage.

You need both to learn what services are covered, and how to get services.

Help From Member Services

You can call us to get answers to your questions at any time. We can help you with questions about benefits and services, to get help with referrals, to replace a lost ID card or to ask about any change that might affect your benefits.

There is someone to help you at Member Services 7 days a week, from 8:00 am to 8:00 pm. Please call 1-877-891-6447 TTY/TDD users, please call 711

SECTION 2. Eligibility for Enrollment in the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program

The Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus is a program for people who have both Medicare and Medicaid. You are eligible to join the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program if you are also enrolled in Elderplan Plus Long-Term Care (HMO D-SNP) for Medicare coverage and:

- Are age 18 and older
- Reside in the plan's service area: Bronx, Kings, Nassau, New York, Queens, Richmond, and Westchester Counties
- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- You are determined eligible for long term care services by Elderplan or entity designated by the Department using the current NYS eligibility tool
- You meet the special eligibility requirements described below.

  a. Must be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to health and safety, based upon criteria provided by New York State Department of Health; and

  b. Medically eligible for nursing home level of care as of the time of enrollment

  c. Must require care management and be expected to need at least one of the following community-based long-term care services for more than 120 continuous days from the effective date of enrollment:

  i. Nursing services in the home;

  ii. Therapies in the home;

  iii. Home health aide services;

  iv. Personal care services in the home;

v. Adult day health care;

vi. Private duty nursing; or

vii. Consumer Directed Personal Assistance Services.

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office For People With Developmental Disability (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program or OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with the Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services waiver program, or OPWDD Day Treatment Program.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program. Enrollment in the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program is voluntary.

SECTION 3. Enrollment In Elderplan Plus Long Term Care (HMO D-SNP) Medicaid Advantage Plus Program

Elderplan Plus Long-Term Care (HMO D-SNP) will process applications in the order in which they are received.

We will determine if you require a New York Medicaid CHOICE Conflict Free Evaluation as part of your application process. You will require a New York Medicaid CHOICE Conflict Free evaluation if you are new to long term care service and are interested in enrolling for the first time or if you have not been enrolled in a plan for the past 45 days. Our enrollment representative will connect you with the New York Medicaid CHOICE Conflict Free Evaluation and Enrollment Center (CFEEC) or you can call directly to 1-855-222-8350 TTY

1-888-329-1546. Individuals transferring from another plan either, Managed Long Term Care or another Medicaid Advantage Plus program do not require a CFEEC evaluation. Transfers that are Medicaid only from mainstream require a CFEEC.

Enrollment:

Once Elderplan Plus Long-Term Care (HMO D-SNP) has determined that you are eligible to enroll, your Medicare application will be submitted to CMS. If CMS confirms your enrollment into Elderplan Plus Long-Term Care (HMO D-SNP), the application and corresponding Medicaid Advantage Plus attestation will be submitted to New York Medicaid Choice (NYMC). All enrollment applications must be signed no later than 15th of the month for the application to be reviewed and submitted to NYMC or LDSS by noon on the 20th of the month to ensure an effective date of the first day of the following month. The effective date of enrollment will be given to you at the time of enrollment. If the effective date changes, Elderplan Plus Long-Term Care (HMO D-SNP) will notify you of the revised effective date. Elderplan Plus Long-Term Care (HMO D-SNP) members will receive a confirmation of enrollment letter which will indicate your effective date of enrollment.

After your application is verified and approved, Elderplan Plus Long-Term Care (HMO D-SNP) will send your member ID card within 10 calendar days. However, if we received and processed your enrollment request towards the end of the month, you may not receive your ID card before your effective date for the following month. If you don't have your ID card and need to see a doctor, call Member Services to verify your coverage and they will fax your eligibility information to your provider. If you have received your confirmation of enrollment letter, you may also use this letter as a proof of coverage until you get member ID card.

If you decide not to proceed with your enrollment application, this will be considered a withdrawal of the application. You may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicated your wishes to us verbally or in writing. If you choose to withdraw your application, you must choose another managed long term care plan in order to continue to receive long term care services, such as personal care. You are no longer able to return to Medicaid Fee for Service services through HRA or LDSS.

Denial of Enrollment:

Elderplan Plus Long-Term Care (HMO D-SNP) will tell you if you are determined to be ineligible based on age, geographical location, or Medicaid/Medicare eligibility.

If Elderplan Plus Long-Term Care's (HMO D-SNP) determines that you do not meet one or more of the eligibility requirements, we will recommend denial of enrollment and you will be notified in writing.

Reasons for Denial of Enrollment Are:

- if after the start of the application process it is determined you are not eligible for nursing home level of care
- if after the start of the application process it is determined that you do not require the community based long term care services offered by Elderplan Plus Long-Term Care (HMO D-SNP) for more than 120 continuous days from the date of enrollment
- if at the time of enrollment, it is determined that you are not able to return to or remain in your home and community without jeopardy to your health and safety

If you do not agree with Elderplan Plus Long-Term Care's (HMO D-SNP) decision regarding your denial of enrollment, you may request to pursue an application with the Local Department of Social Services (LDSS) or NY Medicaid Choice. The information collected up to this time will then be forwarded to the Local Department of Social Services (LDSS) or NY Medicaid Choice and they will make the final decision about your eligibility.

Before the recommendation for denial of enrollment is processed by the LDSS or NY Medicaid Choice, you can withdraw your application by providing your wishes orally or in writing by noon on the 20th of the month.

You will only be denied enrollment if the LDSS or NY Medicaid Choice agrees with Elderplan Plus Long-Term Care's (HMO D-SNP) determination that you are ineligible for enrollment.

If you decide to withdraw your enrollment application prior to the denial of enrollment being processed by LDSS or NY Medicaid Choice, by providing your wishes either orally or in writing, Elderplan Plus Long-Term Care (HMO D-SNP) will send your withdrawal to NYC Human Resources Administration (HRA) or LDSS to process. Elderplan Plus Long-Term Care (HMO D-SNP) will send you a confirmation of your withdrawal in writing.

If Elderplan Plus Long-Term Care (HMO D-SNP) determines that you do not meet one or more of the eligibility requirements, we will recommend a denial of enrollment letter and you will be notified in writing.

SECTION 4. Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program Will Treat You With Fairness And Respect At All Times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services at 1-877-891-6447 (TTY 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Network providers will be paid in full directly by Elderplan Plus Long-Term Care (HMO D-SNP) for each service authorized and provided to you with no copayment or cost to you. If you receive a bill for covered services authorized by Elderplan Plus Long-Term Care (HMO D-SNP), you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program or for covered services that are obtained by providers outside of Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program network.

SECTION 5. Transitional Care

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

Current Members: When your health care 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.

SECTION 6. Monthly Spenddown

Spend down amounts or surplus amounts is the amount of net available income determined by the New York City Human Resources Administration or Local District of Social Services that a member must pay monthly to Elderplan Plus Long-Term Care (HMO D-SNP) in accordance with the requirements of the medical assistance program. Elderplan Plus Long-Term Care (HMO D-SNP) members with a surplus will receive a monthly invoice on or about the 15th of each month.

The amount for which you will be responsible for paying to us will depend on your eligibility for Medicaid and Medicaid's monthly spend down program.

If you are eligible for:	You will pay:
Medicaid (no monthly spend down)	Nothing to Elderplan Plus Long-Term Care (HMO D-SNP)
Medicaid (with monthly spend down)	A monthly spend down to Elderplan Plus Long-Term Care (HMO D-SNP) as determined by New York City Human Resources Administration / Local District of Social Services

If you are eligible for Medicaid with a spend-down and your spend-down changes while you are an Elderplan Plus Long-Term Care (HMO D-SNP) member, your monthly payment will be adjusted.

Elderplan may initiate Involuntary Disenrollment if a member fails to pay any amount owed as a Medicaid spend down within (30) days after such amount becomes due. Elderplan will make reasonable efforts to collect the spend down including written request for payment and advising the members of his/her prospective disenrollment for non-payment.

If you have any questions regarding the Medicaid "spend-down" and live within the five boroughs of Brooklyn, Queens, Staten Island, Manhattan or the Bronx, please contact:

Human Resources Administration
Medical Assistance Program
505 Clermont Avenue, 7th Floor
New York, NY 11238 (718) 557-1399

If you live within Nassau county, please contact:

Nassau County Department of Social Services
60 Charles Lindbergh Blvd.
Uniondale, NY 11553-3656
(516) 227-8519

If you live within Westchester county, please contact:

Westchester County Department of Social Services
112 East Post Road, 5th Floor
White Plains, NY 10601
(914) 995-5000

SECTION 7. Services Covered By The Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage. Chapter 3 of the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. There are no deductibles and copayments. Please read Chapter 4 of the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage What is covered and what you pay.

If there is a monthly premium for benefits (see Chapter 1) of the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage, you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

CARE MANAGEMENT SERVICES:

Coordinating Your Care

Upon enrollment into the Elderplan Plus Long-Term Care (HMO D-SNP), each member is assigned to a Care Management Team, which includes clinical and social care managers along with administrative support. This team is responsible for the coordination of your care and providing you with quality person centered

service planning and Care Management. Together, they will work with you, your informal supports and your primary care physician to ensure you receive the appropriate level of services based on your current and unique psychosocial and medical needs, functional level and support systems. Your Care Management Team will coordinate all of your health care needs for covered and non-covered services, and any other services provided by other providers, community resources and informal supports. You will receive at least one monthly telephone contact from your Care Management Team. The Assessment Nurse, as a member of your Care Management Team, will make home visits at least twice a year to complete a comprehensive assessment of your health and to identify any changes or needs you may have. Additional home visits may be scheduled as determined by your Care Management Team. We will work cooperatively with your physician, who is notified of your plan of care, as well as other health care professionals to ensure you receive the services you need. A Health Care Professional will assist you with applying for any entitlements and other benefits for which you are eligible, as well as in maintaining eligibility through the certification process of all entitlements.

OPTIONS AVAILABLE TO YOU:

Consumer Directed Personal Assistance Services (CDPAS)

CDPAS is a covered voluntary benefit available to all Elderplan Plus Long-Term Care Medicaid Advantage Plus members. CDPAS is a self-directed home care model available to eligible members who are in need of nursing, personal or home care services and are capable of managing their own care. Members who are non-self-directing may have a responsible adult, known as a designated representative, assume the program's responsibilities on their behalf.

If enrolled into CDPAS, you or your representative will have decision making authority regarding recruiting, training, scheduling, evaluating, verification and approval of timesheets and discharge of CDPAS staff.

You may voluntarily discontinue the self-directed option (CDPAS) and receive traditional services through the Medicaid Advantage Plus program at any time.

You may be involuntarily discontinued from the self-directed option if:

- Continued participation in CDPAS would not permit your health, safety or welfare needs to be met;
- You demonstrate the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct services; or
- There is fraudulent use of Medicaid funds such as substantial evidence of falsified documents related to CDPAS.
- Authorization from your physician has exceeded 6 months.

Additional Covered Services

Because you have Medicaid and qualify for the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus program, our plan will arrange and pay for the extra health and social services described below. You may get these services if they are medically necessary, that is, 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 doctor to get these services. You must get these services from the providers who are in Elderplan Plus Long-Term Care's (HMO D-SNP) network.

If you cannot find a network provider in our plan, you must seek prior authorization from Elderplan Plus Long-Term Care (HMO D-SNP) before receiving any health services from an out-of-network provider, except when it is for a medical emergency or urgently needed care. To obtain prior authorization for the services from an out-of-network provider, you or your doctor must call Elderplan Plus Long-Term Care Medical Management at 1-877-891-6447 (TTY 711).

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Personal Care	Assistance with such activities as personal hygiene, dressing and feeding; toileting; walking; meal preparation; and housekeeping. Such services must be essential to the maintenance of your health and safety in your own home.	Personal care services require prior approval.
Person Centered Service Plan (or plan of care)	A written description in the care management record of member-specific health care goals to be achieved and the amount, duration and scope of the covered services to be provided to the member in order to achieve such goals.	Effectiveness of the person-centered service plan is monitored through reassessment and a determination as to whether the health care goals are being met.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Consumer Directed Personal Care Services (CDPAS)	This is a specialized program where a member or a person acting on a member's behalf, known as a designated representative, self directs and manages the member's personal care and other authorized services.	Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping as well as home health aide and nursing tasks. This is provided by an aide chosen and directed by the member or a designated representative. CDPAS requires a physician order and prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Home Health Care Services Not Covered by Medicare	Medicaid covered home health services includes the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care.	Home health care services not covered by Medicare require prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Nutrition	Nutrition services includes the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for your physical and medical needs and environmental conditions. In addition, these services may include planning for provision of appropriate dietary intake within your home environment and the development of a nutritional treatment plan.	Nutritional services require prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Medical Social Services	Medical social services include assessing the need for, arranging for and providing aid for social problems related to the maintenance of your needs in your home when such services are performed by a qualified social worker. Medical social services will assist you with concerns related to your illness, finances, housing or environment.	Medical social services require prior approval.
Home Delivered and Congregate Meals	Meals provided at home or in group settings, e.g. day care centers or senior centers with individuals unable to prepare meals or have them prepared.	Home delivered meals and / or meals in a group setting require prior approval.
Social Day Care	Provides individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period.	Social day care requires prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Non-Emergency Transportation	Transportation services are provided by ambulance, ambulette, taxicab, public transportation or other means appropriate to your medical condition. An attendant to go with you to medical appointments is also covered, if necessary. All non-emergency transportation can be arranged by calling Elderplan Plus Long-Term Care (HMO D-SNP) Member Services 7 days a week from 8:00 am and 8:00 pm at 1-877-891-6447 (TTY 711) or To Make a Reservation: 1-877-779-8611 LogistiCare is available 24/7 to answer member transportation inquiries. Transportation Help Line: 1-877-779-8612 Use this number to call if your transportation is late arriving or to schedule a ride from a facility. Hearing- Impaired Members Call TTY 711 Use this number for reservations to and from a facility or for assistance if your transportation is late in arriving.	All transportation should be arranged three (3) days in advance. If you do not obtain prior authorization from Elderplan Plus Long-Term Care for non-emergent transportation, you will not be reimbursed for the cost of transportation and will be responsible for the full cost. If you prefer to take public transportation (i.e. MTA transit, including subway, bus, Long Island Rail Road, and/or Metro-North Rail Road, etc.), you must submit a completed Member Reimbursement form to Elderplan Plus Long-Term Care (HMO D-SNP) in order for you to receive reimbursement for the cost of the round trip. *continued on next page.*

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Non-Emergency Transportation *continued*		For your convenience, a Member Reimbursement Form is available on our website at www.elderplan.org or you may call Member Services to request one. Simply complete the Member Reimbursement Form and mail to: Elderplan Plus Long Term Care Medicare Plan Member Services 440 9th Avenue, 14th Floor New York, NY 10001 Once your request is received, reimbursement will be mailed to you. Non-emergent transportation requires prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Private Duty Nursing	Private Duty nursing services provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse. Private duty nursing services can be provided through an approved certified home health agency, or a licensed home care agency.	Private duty nursing services require a physician order and prior approval.
Non-Medicare Covered Durable Medical Equipment	Durable medical equipment covered by Medicaid includes items such as tub stools and grab bars that are not otherwise covered by Medicare.	Non-Medicare covered durable medical equipment requires a physician order and prior approval.
Medical/Surgical Supplies	Items for medical use other than drugs, prosthetics, orthotics, durable medical equipment or orthopedic footwear, not otherwise covered by Medicare. Includes enteral nutritional formula. See limitations below.	Non-Medicare covered medical/surgical supplies require a physician order, prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Orthotics and Prosthetics	Includes orthotics, orthopedic footwear and prosthetics.	Non-Medicare covered orthotics and prosthetics require a physician order and prior approval.
Hearing Services	Members of Elderplan Plus Long-Term Care (HMO D-SNP) receive Medicaid-covered hearing services not otherwise covered under Medicare, including hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.	Members must access all Medicaid-covered hearing care, such as routine hearing exams and hearing aids, through the Elderplan Plus Long-Term Care (HMO D-SNP) contracted network. Hearing services do not require prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Vision Members must access all vision care, such as routine eye exams, eyeglasses, and contact lenses through the Elderplan Plus Long-Term Care (HMO D-SNP) contracted vision network, Superior Vision. All covered vision services must be medically necessary.	Members of Elderplan Plus Long-Term Care (HMO D-SNP) receive Medicaid-covered vision services, not otherwise covered under Medicare, including services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease.	In addition, Elderplan Plus Long-Term Care (HMO D-SNP) members receive additional vision benefits beyond those covered by Medicare or Medicaid, including one (1) routine eye exam every two years and one (1) pair of eyeglasses or contact lenses every two years unless medically necessary. Conditions such as glaucoma may require a complete eye examination more frequently than every two years. Routine vision services do not require prior approval. Medically necessary vision services may require prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Dental	Elderplan Plus Long-Term Care (HMO D-SNP) believes that providing you with good dental care is important to your overall health care. We offer dental care through a contract with Healthplex Inc., an expert in providing high quality dental services. Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist!	You must access all dental treatment from providers through Healthplex Inc, the Elderplan Plus Long-Term Care Medicare Plan contracted dental network provider. All covered dental services must be medically necessary. Individual dental procedures may require prior authorization from Healthplex Inc. If you need to find a dentist or change your dentist, please call Healthplex Inc at 1-800-468-0600. Customer Services Representatives are there to help you. Many speak your language or have a contract with language Line Services. Show your Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card. Prior authorization may be required.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Social/Environmental Supports	Social and environmental supports are services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	Social and environmental supports require prior approval.
Personal Emergency Response System	Personal Emergency Response Services (PERS)is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ and signal a response center once a "help" button is activate. In the event of an emergency, the signal is received and appropriately acted upon by a response center.	Personal emergency response system requires prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Adult Day Health Care	Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services.	Adult day health care requires prior approval.
Nursing Home Care not covered by Medicare (provided you are eligible for Institutional Medicaid)	To receive nursing home care services not otherwise covered by Medicare, the services must follow the treatment plan written by the ordering physician, registered physician assistant, certified nurse practitioner or certified home health agency.	Nursing home care not otherwise covered by Medicare requires prior approval.
Inpatient Hospital Care, including Mental Health and Substance Abuse Care	Medically necessary care, including days in excess of the Medicare 190-day lifetime maximum for inpatient mental health.	Inpatient mental health care over the 190-day lifetime Medicare limit requires prior approval.

Benefit	Description of Covered Services	Elderplan Plus Long Term (HMO D-SNP)
Outpatient Mental Health and Substance Abuse	Elderplan Plus Long-Term Care Plan (HMO D-SNP) members may receive outpatient mental health and substance abuse services from any network provider. You can self-refer for one assessment for each benefit from a network provider in a twelve (12) month period.	Outpatient Mental Health and Substance Abuse required prior approval.
Telehealth	Telehealth providers deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of the member through communication technologies.	Telehealth requires a physician order and prior approval.
Outpatient Rehabilitation	Rehabilitation services provided by a licensed and registered therapist, for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level.	Prior authorization is required. See limitations below.

*Limitations:

- Outpatient Physical Therapy is limited to 40 Medicaid visits per year and outpatient Occupational and Speech Therapies are limited to 20 Medicaid visits per therapy per year, except for:
  - —children under age 21
  - —if you have been determined developmentally disabled by the Office for People with Developmental Disabilities
  - —if you have a traumatic brain injury.
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:
  - —1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and
  - —2) 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 considered a permanent placement provided you are eligible for institutional Medicaid coverage.

Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available through 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 are longer
- Have health needs that can be met through services in their 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 Mangers and Discharge Planners. They can help you by:

- Giving you information about service 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 call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gove/mfp or www.ilny.org.

Getting Care Outside the Service Area

If you are away from home or when you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider. "Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

Emergency Service

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.**
- We need to follow up on your emergency care.
- You or someone else should call to tell us about your emergency care, usually within 48 hours. You may do this by calling Member Services at 1-877-891-6447 (TTY 711) 7 days a week from 8am to 8pm.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- or – the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care

Payment of medical emergency services

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
- If the provider is owed anything, we will pay the provider directly.
- If you have already paid for the service, we will pay you back.

SECTION 8. Medicaid Services Not Covered by our Plan

There are some Medicaid services that Elderplan Plus Long-Term Care (HMO D-SNP) does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-877-891-6447 (TTY 711) if you have a question about whether a benefit is covered by Elderplan Plus Long-Term Care (HMO D-SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

Most prescription drugs are covered by Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Part D as described in Chapter 5 of the Elderplan Plus Long-Term Care (HMO D-SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Elderplan Plus Long-Term Care (HMO D-SNP) or 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
- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management

Family Planning

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

SECTION 9. Services Not Covered By Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program

You must pay for services that are not covered by Elderplan Plus Long-Term Care (HMO D-SNP) or by Medicaid 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 Elderplan Plus Long-Term Care (HMO D-SNP) or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless Elderplan Plus Long-Term Care (HMO D-SNP) sends you to that provider)

If you have any questions, call Member Services at 1-877-891-6447 (TTY 711).

SECTION 10. Service Authorizations and Actions

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a service authorization request (also known as a coverage decision request). To get a service authorization request, you or your doctor must call Elderplan Plus Long-term Care Medical Management at 1-877-891-6447 (TTY 711) or send your request in writing to:

Elderplan Plus Long Term Care
Medicare Plan Medical Management Department
6323 7th Avenue
Brooklyn, NY 11220

We will authorize services in a certain amount and for a specific period of time. This is called an authorization period.

Prior Authorization

Some covered services require prior authorization (approval in advance) from Elderplan Plus Long Term Care Medical Management before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved before you get them:

- Non-par services- Elective Admission, SNF admissions/Acute Rehab
- Non-emergent ambulance
- Physical Therapy/Comprehensive Outpatient Rehabilitation Facilities (i.e., outpatient rehabilitation care)
- Wound Care/Vacuum Procedures
- Hyperbaric O2 Therapy
- DME/Supplies- Medicare products
- DME/Supplies- Medicaid products

- Transplant Evaluation
- Prosthetic & Orthotics
- MRI/MRA/Pet/CT
- Diabetic Shoes
- Community Based Long Term Care Services (CBLTC)
- Medicaid covered non-emergent transportation
- Home Visiting Specialists

Concurrent Review

You can also ask Elderplan Plus Long Term Care Medical Management 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.

What happens after we get your service authorization request

The health plan has a review team to be sure you get the services we promise. 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 you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called clinical review criteria, used to make the decision about medical necessity.

After we get your request, we will review it under either a standard or a fast track process. You or your provider can ask for a fast track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast track review, we will tell you and handle your request 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 mentioned below. More information on the fast track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the standard timeframe for giving you our decision about your request for a medical item or service unless we have agreed to use the fast track deadlines.

A standard review for a prior authorization request means we will give you an answer within 3 work days of when we have all the information we need, but no later than 14 calendar days after we get your request. If your case is a concurrent review where you are asking for a change to a service you are already getting, we will make a decision within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.

We can take up to 14 more calendar days if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.

If you believe we should **not** take extra days, you can file a **"fast complaint."** When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 14: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

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.

Section 11: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

If your health requires it, ask us to give you a "fast service authorization."

- A fast review of a prior authorization request means we will give you an answer within 1 work day of when we have all the information, we need but no later than 72 hours from when you made your request to us.
- We can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.

- If you believe we should not take extra days, you can file a "fast complaint" (For more information about the process for making complaints, including fast complaints, see Section 14: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 11: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)
2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

If your provider tells us that your health requires a "fast service authorization," we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider's support, we will decide whether your health requires that we give you a fast service authorization.

If we decide that your medical condition does not meet the requirements for a fast service authorization, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see Section 14: What To Do If You Have A Complaint About Our Plan later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 11: Level 1 Appeals, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 11: Level 1 Appeals, below for more information.

If we are changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are checking care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to Chapter 9 of the Elderplan Plus Long Term Care (HMO D-SNP) Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care

If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- Elderplan Plus Long Term Care (HMO D-SNP) can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-877-891-6447 (TTY 711) to get more information on your rights and the options available to you.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

SECTION 11. Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 10 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have 60 days from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision, we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **"fast appeal."**
  - -The requirements and procedures for getting a "fast appeal" are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 10, in the Fast Track Process section.)
  - -If your provider tells us that your health requires a "fast appeal," we will give you a fast appeal.
  - -If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.

- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at 1-877-891-6447 (TTY 711) if you need help filing a Level 1 Appeal.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an "Appointment of Representative" form, or write and sign a letter naming your representative.
    - To get an "Appointment of Representative" form, call Member Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at https://www.elderplan.org/for-members/appoint-a-representative. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
    - You can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing.

Continuing your service or item while appealing a decision about your care

- If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.
- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.

- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-877-891-6447 (TTY 711) if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a "standard" appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request within **30 calendar days** after we get your appeal if your appeal is about coverage for services you have not gotten yet.
- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
  - -If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
  - -For more information about the process for making complaints, including fast complaints, see Section 14: What To Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
  - -An independent outside organization will review it.
  - -We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 13: Level 2 Appeals.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, we are required to send your appeal to the next level of appeal. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a "fast" appeal

- When we are using the fast timeframes, **we must give you our answer within 72 hours** after we get your appeal. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will 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.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 13: Level 2 Appeals.

If our answer is yes to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

If our answer is no to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the **"Integrated Administrative Hearing Office"** or "Hearing Office," reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.
- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 13: Level 2 Appeals.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 12. External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only.**

You can ask New York State for an independent external appeal if our plan decides to deny coverage for a medical service you and your doctor asked for because it is: not medically necessary or

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

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement. To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services at 1-877-891-6447 (TTY 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at 1-877-891-6447 (TTY 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that 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 the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

SECTION 13. Level 2 Appeals

Information in this section applies to **all** of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

If we say **No** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency.** It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your "case file." Y**ou have the right to ask us for a free copy of your case file.**
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 35 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you it's decision in writing and explain the reasons for it.

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision.**
- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the Hearing Office says no to part or all of your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.
- The decision you get from the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

SECTION 14. What To Do If You Have A Complaint About Our Plan

Information in this section applies to all of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-877-891-6447 (TTY 711) or write to Member Services. **The formal name for "making a complaint" is "filing a grievance."**

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know at 1-877-891-6447 (TTY 711), 7 days a week from 8 am to 8 pm.

- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing. You can write us with your complaint or call the Member Services number. If you write us, it should be mailed to: 6323 Seventh Avenue, Brooklyn, NY 11220.
- To file a complaint with the plan by phone, call Member Services at 1-877-891-6447 (TTY 711), 7 days a week from 8 am to 8 pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.
- **Whether you call or write, you should contact Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **We answer most complaints in 30 calendar days.**
- If you are making a complaint because we denied your request for a "fast service authorization" or a "fast appeal," **we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you an **answer within 24 hours**.
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness.

Here are examples of when you can make a complaint:

- If you asked us to give you a "fast service authorization" or a "fast appeal" and we said we will not.
- If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
- When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
- When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

If you disagree with a decision, we made about your complaint about your Medicaid benefits, you or someone you trust can file a complaint appeal with the plan.

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information, we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale, if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

Participant Ombudsman

The Participant Ombudsman is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. These services include, but are not necessarily limited to:

i. Providing pre-enrollment support, such as unbiased health plan choice counseling and general program related information;

ii. Compiling member complaints and concerns about enrollment, access to services, and other related matters;

iii. Helping members understand the fair hearing, complaint and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/requested, including making requests of plans and providers for records, and

iv. Informing plans and providers and community-based resources and supports that can be linked with covered plan benefits.

At this time, the Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN is available to answer long-term care member's questions regarding member rights, Medicare, Medicaid and long-term care services. ICAN can also assist members with resolution of any issues related to access to care and with filing appeals and complaints.

ICAN Contact Information:

ICAN may be reached toll-free at 1-844-614-8800, TTY 711, or online at icannys.org.

New York State Department of Health Information:

If Elderplan Plus Long-Term Care (HMO D-SNP) is unable to resolve complaints or issues, you can also reach New York State Department of Health and file a complaint at any time 1-866 712-7197.

SECTION 15. Disenrollment From Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program

We will treat you with fairness and respect at all times. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call member services at 1-877-891-6447 (TTY 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

You Can Choose to Dis-enroll

You can ask to leave the Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus program at any time for any reason. To request disenrollment, call:

- Elderplan Plus Long-Term Care (HMO D-SNP) Member Services at 1-877-891-6447 (TTY 711) It could take up to six weeks to process, depending on when your request is received.

If you dis-enroll from Elderplan Plus Long-Term Care (HMO D-SNP), but are still in need of community based long-term care services, New York State may require you to join a managed long-term care plan (MLTCP) or a waiver program to continue to receive these services, since community long-term care services are no longer covered by New York's Fee-For-Service Medicaid Program.

You Will Have to Leave Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program if you:

- No longer are in Elderplan Plus Long-Term Care (HMO D-SNP) for your Medicare coverage
- Need nursing home care, but are not eligible for institutional Medicaid
- No longer have full Medicaid coverage
- Are out of the plan's service area for more than 30 consecutive days
- Are assessed as no longer eligible for nursing home level of care as determined at any comprehensive assessment using the assessment tool prescribed by the State Department of Health, unless Elderplan or the LDSS or entity designated by the State agree that termination of the services provided by Elderplan could reasonably be expected to result in you being eligible for nursing home level of care (as determined with the assessment tool prescribed by the State Department of Health) within the succeeding six-month period. Elderplan shall provide the LDSS or entity designated by the State the results of its assessment and recommendations regarding continued enrollment or disenrollment within five (5) business days of the comprehensive assessment
- Become incarcerated
- Join a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People with Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan

We will ask that you leave Elderplan Plus Long-Term Care (HMO D-SNP) Medicaid Advantage Plus Program for the following reasons:

- If you, or a family member or informal caregiver engages in conduct or behavior that seriously impairs Elderplan's ability to furnish service either to you or other members.
- If you fail to pay or make arrangements satisfactory to Elderplan to pay the amount owed as a Medicaid surplus to Elderplan within (30) thirty days after it becomes due.
- If you provide Elderplan with false information, otherwise deceive Elderplan or engage in fraudulent conduct with respect to any substantive aspect of your membership.
- If you fail to complete and submit any necessary consent or release

Re-Enrollment Provisions

If you voluntarily dis-enroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily dis-enrolled, for any reason, you may complete a new application for re-enrollment at any time. If you are eligible for enrollment described earlier in this Handbook, you will be re-enrolled.

SECTION 16. Rights and Responsibilities

As a member in Elderplan Plus Long-Term Care (HMO D-SNP), you have the Right:

1. To receive medically necessary care.
2. To timely access to care and services.
3. To privacy about your medical record and when you get treatment.
4. To get information on available treatment options and alternatives presented in a manner and language you understand.

5. To get information in a language you understand; you can get oral translation services free of charge.
6. To get information necessary to give informed consent before the start of treatment.
7. To be treated with respect and dignity.
8. To get a copy of your medical records and ask that the records be amended or corrected.
9. To take part in decisions about your health care, including the right to refuse treatment.
10. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
11. To get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
12. To be told where, when and how to get the services you need from Elderplan Plus Long-Term Care (HMO D-SNP), including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
13. To complain to the New York State Department of Health.
14. To complain to your local department of social services and the right to use the New York State Fair Hearing system.
15. To appoint someone to speak for you about your care and treatment.
16. To make advance directives and plans about your care.

Responsibilities of Members

To have the greatest benefit from enrollment in Elderplan Plus Long-Term Care (HMO D-SNP), you have the following responsibilities:

1. To Participate Actively in Your Care and Care Decisions

- To communicate openly and honestly with your doctor and Care Team about health and care.
- To ask questions to be sure you understand your service plan and to consider consequences of not following your service plan. Your care plan and changes to your Care Plan will be discussed and documented as part of our monthly care management call.
- To share in care decisions and continue to be in charge of your own health.
- To complete self-care as planned.
- To keep appointments or inform the Team of needs to change appointments
- To use the Elderplan Plus Long-Term Care (HMO D-SNP) Network Providers for care except in emergency situations.
- To notify Elderplan Plus Long-Term Care (HMO D-SNP) if you receive health services from other health care providers.
- To participate in policy development by writing to us, or calling us.

2. To Support the Elderplan Plus Long-Term Care (HMO D-SNP)

- To appropriately express opinions, concerns and suggestions in the following ways including, but not limited to, express your opinions or concerns to your Care Team, or through the Elderplan Plus Long-Term Care (HMO D-SNP) Appeals and Compliant Process.
- To review the Member Handbook and follow procedures to receive services.

- To respect the rights and safety of all those involved in your care and to assist
- Elderplan Plus Long-Term Care (HMO D-SNP) in maintaining a safe home environment.
- To notify your Care Team at Elderplan Plus Long-Term Care (HMO D-SNP) of any of the following;
- if you are leaving the service area
- if you have moved or have a new telephone number
- if you have changed Doctors
- any changes in condition that may affect our ability to provide care

SECTION 17. Advanced Directives

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you; your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors** written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

SECTION 18. Notice of Information Available On Request

The following information is available upon request by the member:

- A list of names, business addresses and official positions of the members of Elderplan Plus Long-Term Care (HMO D-SNP)'s Board of Directors, officers, controlling partners, and owners or partners.
- A copy of the most recent annual certified financial statement of Elderplan Plus Long-Term Care (HMO D-SNP) including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant.
- Information related to member complaints and aggregated information about complaints and appeals.
- Elderplan Plus Long-Term Care (HMO D-SNP) procedures for protecting confidentiality of medical records and other member information.
- A written description of the organizational arrangement and ongoing procedures of Elderplan Plus Long-Term Care (HMO D-SNP)'s Quality Assurance Program
- A description of the procedures followed by Elderplan Plus Long-Term Care (HMO D-SNP) in making decisions about the experimental, or investigational nature of individual drugs, medical devices or treatments in clinical trials
- Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information which Elderplan Plus Long-Term Care (HMO D-SNP) might consider in its utilization review and how it is used in the utilization review process, provided, however, that to the extent that such information is proprietary to Elderplan Plus Long-Term Care (HMO D-SNP), the member or prospective member shall only use the information for the purpose of assisting the member/prospective member in evaluating the covered services provided by Elderplan Plus Long-Term Care (HMO D-SNP)

Disclaimer Information:

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the plan.

Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2016.

Medicare Part B premium is covered for full-dual members.

Eligible beneficiaries can enroll at any time. Contact Elderplan Plus Long-Term Care (HMO D-SNP) for additional information.

This information is available for free in other languages. Please contact our Member Services number at 1-877-891-6447 for additional information. (TTY users should call 711). Hours are 7 days a week from 8am to 8pm. Member Services has free language interpreter services available for non-English speakers.

This information is available in a different format, including translation into Spanish, Chinese, Braille, and large print. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información está disponible en forma gratuita en otros idiomas. Por favor, comuníquese con nuestro número de Servicios a los Miembros al 1-877-891-6447 para obtener más información. (Los usuarios de TDD/TTY deben llamar al (711). Los 7 días de la semana, de 8:00 a.m. a 8:00 p.m. Servicios a los Miembros dispone de servicios gratuitos de interpretación de idiomas para las personas que no hablan inglés.

Esta información está disponible en diferentes formatos, entre ellos, traducciones al español, en formato Braille y en letra grande. Por favor, llame a Servicios a los Miembros al número que figura previamente si necesita información sobre el plan en otro formato o idioma.

本資訊亦可以其他語言免費提供。更多資訊請聯絡我們的會員服務部,電話號碼是1-877-891-6447 。(聽力語言殘障人士請致電TDD/TTY 711)。服務時間每週七天,
每天上午8時至下午8時。會員服務部可為不能講英語的人士提供免費口譯服務。
此資訊可以不同形式提供,包括譯成西班牙語與中文,盲文,及大字印本。如果您霄要以其他
形式或語言的計劃資料,請致電上列的會員服務部電話號碼。

Method	Member Services – Contact Information
CALL	1-800-353-3765 Calls to this number are free. 8 a.m. to 8 p.m.,7 days a week Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8 a.m. to 8 p.m., 7 days a week
FAX	(718) 630-2624
WRITE	Elderplan, Inc. Elderplan for Medicaid Beneficiaries 6323 7th Avenue Brooklyn, NY 11220
WEBSITE	www.elderplan.org

Health Insurance Information, Counseling and Assistance Program (HIICAP) New York SHIP

Health Insurance Information, Counseling and Assistance Program (HIICAP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Member Services – Contact Information
CALL	1-800-701-0501
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Health Insurance Information Counseling and Assistance Program 2 Lafayette Street 7th Floor New York, NY 10007-1392
WEBSITE	http://www.aging.ny.gov/healthbenefits

Elderplan/HomeFirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Elderplan, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Elderplan/HomeFirst.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - —Qualified sign language interpreters
  - —Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

  —Qualified interpreters

  —Information written in other languages

If you need these services, contact Civil Rights Coordinator. If you believe that Elderplan/HomeFirst has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you may file a complaint with:

Civil Rights Coordinator
6323 7th Avenue Brooklyn, NY, 11220
Phone: 1-877-326-9978, TTY 711
Fax: 1-718-759-3643

You may file a complaint in person or by mail, phone, or fax. If you need help filing a complaint, Civil Rights Coordinator, is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/ portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW, Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019,
1-800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak a non-English language or require assistance in ASL, language assistance services, free of charge, are available to you. Call 1-800-353-3765 (TTY: 711).

(Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-353-3765 (TTY: 711).

(Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-353-3765 (TTY: 711).

(Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-353-3765 (телетайп: 711).

(French Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-353-3765 (TTY: 711).

(Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-800-353-3765 (TTY: 711)번으로 전화해 주십시오.

(Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-353-3765 (TTY: 711).

(Yiddish) אם: שידיא טדער ריא ביוא, ענעז ואהראפ ראפ רייא ראפש ווען יירפ סעסיוורעס הליה

לאצפא. טפור 1-800-353-3765 (TTY: 711).

(Bengali) লক্ষ্য করুনঃ যদি আপনি বাংলা কথা বলতে পারনে, তাহলে নিঃখরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে।

ফোন করুন 1-800-353-3765 (TTY: 711)।

(Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej.

Zadzwoń pod numer 1-800-353-3765 (TTY: 711).

(Arabic)ملحوظة:إذا كنت تتحدث لغة غير الإنجليزية أو تحتاج إلى مساعدة في ASL، فإن خدمات المساعدة اللغوية تتوافر لك مجانا. اتصل برقم 1-800-353-3765 (TTY: 711)

(French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-353-3765 (ATS: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں - کال کریں (Urdu) 1-800-353-3765 (TTY: 711)

(Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-353-3765 (TTY: 711).

(Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-353-3765 (TTY: 711).

(Albanian) KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-353-3765 (TTY: 711).

elderplan homefirst®
a member of MJHS Health System

For more information, call us toll-free
1-877-891-6447.
8 a.m.–8 p.m., 7 days a week.

TTY/TDD users should call
711

Visit our website
Elderplan.org

Elderplan is an HMO plan with Medicare and Medicaid contracts. Enrollment in Elderplan depends on contract renewal.