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Elderplan.org

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

Medicaid Handbook

Elderplan is an HMO plan with Medicare and Medicaid contracts. Enrollment in Elderplan depends on contract renewal. Anyone entitled to Medicare Parts A and B may apply. Enrolled members must continue to pay their Medicare part B premium if not otherwise paid for under Medicaid.

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Current as of 11/4/2024

Medicaid Member Handbook

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

Welcome to Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) covers since you are enrolled in the Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicaid Advantage Plus Program. It also tells you how to request a service, file a complaint or disenroll from Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) Medicare Evidence of Coverage (EOC). Keep this handbook with the Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicare Evidence of Coverage (EOC). You need to learn both what services are covered and how to get them.

Help From Member Services

You can call Member Services at 1-877-891-6447 (TTY: 711), 8 a.m. – 8 p.m., 7 days a week for assistance 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. You can also call us during after hours as well.

We can also provide translated materials as well as in alternative formats such as braille, audio CD, or other formats you need. Please call Member Services for more information.

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

Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) Medicaid Advantage Plus Program if you are also enrolled in Elderplan Plus Long-Term Care (HMO-POS 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, Dutchess, Orange, Putnam, Rockland, Sullivan,* Ulster,* and Westchester Counties;
- Have Medicaid;
- Have evidence of Medicare Part A & B;
- You are determined eligible for long-term care services by Elderplan or entity designated by the New York State Department of Health using the current NYS eligibility tool; and
- 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 (NHLOC) 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 (Level 2);

v. Adult day health care;

vi. Private duty nursing; or

vii. Consumer Directed Personal Assistance Services

d. Be enrolled in the Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicaid Advantage Plus Program

Please note that Personal Care Services include two levels of care:

(1) Performance of nutritional and environmental support functions:

- Making and changing beds;
- Dusting and vacuuming the rooms which the patient uses;
- Light cleaning of the kitchen, bedroom and bathroom;
- Dishwashing;
- Listing needed supplies;
- Shopping for the patient if no other arrangements are possible;
- Patient's laundering, including necessary ironing and mending;
- Payment of bills and other essential errands; and
- Preparing meals, including simple modified diets.

(2) Personal care functions:

- Bathing of the patient in the bed, the tub or in the shower;
- Dressing;
- Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;
- Toileting; this may include assisting the patient on and off the bedpan, commode or toilet;

- Walking, beyond that provided by durable medical equipment, within the home and outside the home;
- Transferring from the bed to chair or wheelchair;
- Turning and positioning;
- Preparing of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diets;
- Feeding
- Administration of medication by the patient, including prompting the patient as to time, identifying the medication for the patient, bringing the medication and any necessary supplies or equipment to the patient, opening the container for the patient, positioning the patient for medication and administration, disposing of used supplies and materials and storing the medication properly;
- Providing routine skin care;
- Using medical supplies and equipment such as walkers and wheelchairs; and
- Changing of simple dressings.

An applicant is not eligible to enroll into the Elderplan Plus Long-Term Care Plan (HMO-POS D-SNP) if they are:

- a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Addiction Services and Supports (OASAS) or the State Office For People With Developmental Disabilities (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.

An applicant who is receiving services from a hospice may be eligible to enroll into the plan 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.

Elderplan Plus Long-Term Care (HMO-POS D-SNP) members must choose a Primary Care Provider (PCP) from the Elderplan network.

If you decide to change your Medicare plan, you will also have to leave Elderplan Plus Long-Term Care (HMO-POS D-SNP) Program, and must also change your managed long-term care plan.

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

*Pending DOH approval of service area expansion.

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

The New York State Department of Health (DOH) uses the New York Independent Assessor Program (NYIAP), formerly known as the Conflict-Free Evaluation and Enrollment Center (CFEEC), to support the assessment process for all long-term care plans. The NYIAP manages the initial and expedited initial assessment process. The initial process includes completing the:

- Community Health Assessment (CHA): The CHA is used to see if you need personal care services (PCS) and/or consumer directed personal assistance services (CDPAS) and are eligible for enrollment in a Managed Long-Term Care plan.
- Clinical appointment and Practitioner Order (PO): The PO documents your clinical appointment and indicates that you:
    - o have a need for help with daily activities, and
    - o that your medical condition is stable so that it is safe for you to receive PCS and/or CDPAS in your home.

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

will use the CHA and PO outcomes to determine what kind of help you need and create your plan of care.

If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day, on average, a separate review by the NYIA Independent Review Panel (IRP) will be required by DOH. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care and any other medical documentation. If more information is needed, someone on the panel may schedule you for a physical exam or contact you to discuss your needs. The IRP will make a recommendation to Elderplan about whether the plan of care meets your needs.

On an annual basis, Elderplan will reassess your plan of care, ongoing health care needs and supports to ensure that you still meet the long term care eligibility requirements of the Medicaid Advantage Plus Plan Program.

Enrollment:

Elderplan Plus Long-Term Care (HMO-POS D-SNP) will process applications in the order in which they are received. Once Elderplan Plus Long-Term Care (HMO-POS D-SNP) has determined that you are eligible to enroll under Medicare and Medicaid requirements, your application will be submitted to New York Medicaid Choice (NYMC) and the Centers for Medicare and Medicaid Services (CMS). Elderplan will submit your Medicaid Advantage Plus enrollment request to NYMC to review and process for the Medicaid portion. Elderplan will submit your Medicare enrollment request to CMS to review and process the Medicare portion. Both the Medicare and Medicaid portions of your enrollment must be confirmed by CMS and NYMC respectively for you to enroll in Elderplan Plus Long-Term Care (HMO-POS D-SNP).

After your application is verified and approved, Elderplan Plus Long-Term Care (HMO-POS D-SNP) will send your member ID card within 10 calendar days from the date the enrollment is confirmed. We will submit your enrollment application to CMS between the 1st of the month to the 24th of the month. Once we receive CMS confirmation of your enrollment, we will then submit your enrollment application to NYMC on or before the 25th of the month. If the 25th falls on a weekend, the deadline will be the preceding Friday.

You will receive a letter confirming your enrollment (known as the Notice of Acknowledge Enrollment and Confirmation) which will indicate your effective date of Plan coverage. This letter is proof of insurance and prescription drug coverage that you should show during your doctor appointments or at the pharmacy until you get your Member ID card from us. If you do not have your Member 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 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 indicating your wishes to us verbally or in writing before noon on the 25th day of the month prior to the effective date of enrollment. We will notify NYMC and CMS of your application and/or enrollment withdrawal request.

If you choose to withdraw your application or enrollment request and you need long term care services, 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 the New York City Human Resources Administration (HRA) or LDSS.

Denial of Enrollment:

Elderplan Plus Long-Term Care (HMO-POS 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 (HMO-POS 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-POS 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-POS D-SNP) decision regarding your denial of enrollment, you may request to pursue an application with the LDSS or NY Medicaid Choice. The information collected up to this time will then be forwarded to the 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 verbally or in writing by noon on the 25th 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-POS 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 indicating your wishes either verbally or in writing, Elderplan Plus Long-Term Care (HMO-POS D-SNP) will send your withdrawal to HRA or LDSS to process. Elderplan Plus Long-Term Care (HMO-POS D-SNP) will send you a confirmation of your withdrawal in writing.

If Elderplan Plus Long-Term Care (HMO-POS 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-POS 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-POS 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-POS D-SNP), you are not responsible for payment. Please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by the plan or for covered services that are obtained by providers outside of the Elderplan 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 90 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.

For current members, an ongoing course of treatment may be continued for transitional period of 90 days when your health care provider leaves the network. Your provider must accept payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

If you feel you have a condition that meets the criteria for transitional care services, please notify your Care Management Team. If you are being disenrolled from a managed long-term care (MLTC) plan or Medicare Advantage Plan (MAP) into Elderplan due to an approved service area reduction, closure, acquisition, merger,

or other approved arrangement, Elderplan must continue to provide services. We will continue services under your current existing Person Centered Service Plan for a continuous period of 120 days after enrollment, or until Elderplan has conducted an assessment and you have agreed to the new Person Centered Service Plan.

SECTION 6. Monthly Spenddown

"Spenddown," also referred to as surplus amounts or surplus amounts is Net Available Monthly Income (NAMI) amount that the member must pay to Elderplan on a monthly basis to meet the eligibility requirements for Medicaid. This amount is determined by HRA, LDSS, or entity designated by DOH. Members with a surplus will receive a monthly invoice on or about the 15th of each month.

The amount that you must pay will depend on your eligibility for Medicaid and Medicaid's monthly spenddown program.

If you are eligible for:	You will pay:
Medicaid (no monthly spenddown)	Nothing to Elderplan.
Medicaid (with monthly spenddown)	A monthly amount to Elderplan, as determined by HRA, LDSS, or an entity designated by DOH.

Elderplan is required to bill for this amount. If you are eligible for Medicaid with a spenddown and the amount changes while you are an Elderplan Plus Long-Term Care (HMO-POS 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 spenddown within 30 days after the due date. Elderplan will make reasonable efforts to collect the spenddown 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 Spenddown and live within the five boroughs of Brooklyn, Queens, Staten Island, Manhattan or the Bronx, please contact:

Human Resources Administration
Medical Assistance Program
785 Atlantic Avenue, 1st Floor
Brooklyn, NY 11238 | 1-888-692-6116

If you live within Dutchess County, please contact:

Dutchess County Community and Family Services
60 Market Street
Poughkeepsie, NY 12601 | 845-486-3000

If you live within Nassau county, please contact:

Nassau County Department of Social Services
60 Charles Lindbergh Blvd.
Uniondale, NY 11553-3656 | 516-227-8000

If you live within Orange County, please contact:

Orange County Department of Social Services
11 Quarry Road
Goshen, NY 10924 | 845-291-4000

If you live within Putnam County, please contact:

Putnam County Department of Social Services
110 Old Route Six Buliding #2
Carmel, NY 10512 | 845-808-1500 Ext: 45251

If you live within Rockland County, please contact:

Rockland County Department of Social Services
Rockland County 50 Sanatorium Rd
Pomona, NY 10970 | 845-364-3040

If you live within Sullivan County, please contact:

Sullivan County Department of Social Services
P.O. Box 231
16 Community Lane
Liberty, NY 12754 | 845-292-0100

If you live within Ulster County, please contact:

Ulster County Department of Social Services
1061 Development Court
Kingston, NY 12401 | 845-334-5000

If you live within Westchester County, please contact:

Westchester County Department of Social Services
85 Court Street
White Plains, NY 10601 | 914-995-3333

SECTION 7. Services Covered By The Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) Medicare Evidence of Coverage (EOC). You can also see providers in our network, get care in a medical emergency and go to urgent care if needed. Since you have Medicaid coverage, you do not have any premiums, deductibles, and copayments in this plan.

Your Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicare Evidence of Coverage (EOC) will give you all the Medicare benefits and covered services. See the EOC Chapters below in the Evidence of Coverage for more details about your coverage:

- **Chapter 1**, "Getting Started as A Member," which describes any premiums for monthly benefits.
- **Chapter 3**, "Using The Plan For Your Medical and Other Covered Services," which explains the rules for using plan providers and getting care in a medical emergency or if urgent care is needed.
- **Chapter 4**, "Medical Benefits Chart (What is Covered)," which explains what benefits are covered and any cost-sharing (copayments or co-insurance).

You can review the EOC on our website at elderplan.org or call Member Services at 877-891-6447 (TTY: 711), 8 a.m. – 8 p.m., 7 days a week, to request a copy.

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-POS D-SNP) plan, each member is assigned to a Care Management Team, which includes a registered nurse, assessor, care managers, and care representatives. This team is responsible for the coordination of your ongoing care and providing you with a high-quality person-centered service planning experience.

The Person Centered Service Plan (PCSP) or Plan of Care (POC) is a written description in our care management record of your health care goals, and the amount, duration, and scope of the covered services that is provided to achieve such goals. The PCSP must be developed with you and those individuals you select to participate in service planning and delivery, including service providers and your chosen informal supports. Our care managers will talk to you about your cultural preferences and range of services (i.e., scope, duration, amount, and

frequency) to develop this plan. Services will not be planned or authorized until our care manage meets and collaborates with you.

Together, our Care Management Team will work with you, your informal supports and your primary care provider to ensure you receive the appropriate level of services based on your current and unique psychosocial and medical needs, functional level and support systems. Our Care Management Team will also support and coordinate all your health care needs for covered and non-covered services, and any other services provided by other providers, community resources and informal supports.

Our Care Management team will reach out to you at least once a month by phone to see how you are doing. The Nurse Assessor, as a member of your Care Management Team, will make a home visit annually 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 provider, 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 AVAILBLE 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 need 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 you are 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 personal care services provided by a licensed home care services agency (LHCSA) through the Medicaid Advantage Plus program at any time.

You may not be able to receive CDPAS services 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;
- There is fraudulent use of Medicaid funds such as substantial evidence of falsified documents related to CDPAS; or
- Authorization from your physician has exceeded 6 months.

Additional Medicaid Covered Services

Because you have Medicaid and qualify for the Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicaid Advantage Plus program, we will arrange and pay for the extra health and social services described below. You may get these services if they are medically necessary (i.e., 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 an authorization 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-POS 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-POS 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
Care Management	A process that assists the member to access necessary covered services as identified in the Person Centered Service Plan (PCSP). Care management services include referrals to in-network providers, assistance in or coordination of services for the member to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in the benefits.
Nursing Home Care	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. Members must be eligible for institutional Medicaid coverage. Prior authorization is required.
Home Health Care Services	Medicaid-covered home health services include the provision of skilled services not covered by Medicare. This includes preventive, therapeutic rehabilitative, health guidance and/or supportive care. Covered services include: • Services provided by a home health aide • Physical Therapy (PT) in the home • Occupational Therapy (OT) in the home • Speech Language Pathology (SP) in the home Additional examples include 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. Prior authorization is required.

Benefit	Description of Covered Services
Personal Care Services (PCS)	Provision of some or total assistance with such activities as personal hygiene, dressing and feeding; toileting; walking; meal preparation; and housekeeping. Such services must be medically necessary, essential to the maintenance of your health and safety in your own home, and provided by a qualified person in accordance with the plan of care. Prior authorization is required.
Consumer Directed Personal Assistance Services (CDPAS)	Consumer Directed Personal Assistance Service (CDPAS) 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. CDPAS members have freedom in choosing their personal aide, home health services and/or skilled nursing services that they are eligible to receive. CDPAS requires a practitioner order and prior authorization.
Durable Medical Equipment (DME)	Durable medical equipment, including devices and equipment other than prosthetic or orthotic appliances, and having the following characteristics: • Can withstand repeated use for a protracted period of time; • are primarily and customarily used for medical purposes; • are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Examples of non-Medicare covered durable medical equipment (i.e., covered by Medicaid) includes items such as tub stools, grab bar, or hearing aid batteries. Prior authorization is required.

Benefit	Description of Covered Services
Medical and Surgical Supplies	Items for medical use other than drugs, prosthetics, orthotics, durable medical equipment or orthopedic footwear. These items are generally considered to be one-time only use, consumable items. Includes enteral nutritional formula coverage, which is limited to tube feeding and inborn metabolic diseases, and oral nutritional supplements. For members between the ages of 18 and 21, oral formulas remain covered when caloric and dietary nutrients cannot be absorbed or metabolized. Prior authorization is required.
Orthotics and Prosthetics	Items covered include: • Orthotics (such as splints or braces), • Orthopedic footwear (specially designed footwear to provide support, comfort and relief based on foot and lower limb medical conditions); and • Prosthetics (artificial replacement of a body part). Prior authorization is required.
Personal Emergency Response System (PERS)	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 activated. In the event of an emergency, the signal is received and appropriately acted upon by a response center. Prior authorization is required.

Benefit	Description of Covered Services
Podiatry	Includes routine foot care when the member's physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as a necessary and integral part of medical care, such as the diagnosis and treatment of diabetes, ulcers and infections. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails and other hygienic care, such as cleaning or soaking feet, is not covered in the absence of a medical condition. Prior authorization is required.
Dental	Covered services include regular and routine dental services such as preventive dental check-ups, cleanings, x-rays, fillings, supplies, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. We also cover crowns and root canals in certain circumstances so that you can keep more natural teeth. In addition, replacement dentures and implants will only need a recommendation (not a referral) from your dentist to determine if they are necessary. This will make it easier for you to access these dental services. You must access all dental treatment from providers through Healthplex, our dental network. You do not need a referral from your PCP to see a dentist. All covered dental services must be medically necessary. Individual dental procedures may require prior authorization from Healthplex. If you need to find a dentist or want to change your dentist, please call Healthplex at 1-866-795-6493. They can assist in the language you speak or have translators available to support your needs. Remember to show your Elderplan Member ID card when you visit your dentist or whenever you access dental benefits. You will not receive a separate dental ID card. Prior authorization may be required.

Benefit	Description of Covered Services
Vision	Members 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. Vision benefits also include 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. Members must access all vision care, such as routine eye exams, eyeglasses, and contact lenses through Superior Vision. Routine vision services do not require prior approval. Medically necessary vision services may require prior approval.
Hearing/Audiology	Hearing services and products care covered 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. Hearing aid products including hearing aids, earmolds, special fittings and replacement parts. Prior authorization is required.

Benefit	Description of Covered Services
Outpatient Rehabilitation	Rehabilitation therapy includes Physical Therapy (PT), Occupational Therapy (OT), Speech Language Pathology (SP), or other rehabilitative therapies provided in a setting other than a home. There are no limits to Medicaid-covered visits. 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 their best functional level, provided in a setting other than a home. Prior authorization is required.
Respiratory Therapy	Respiratory therapy is used to treat chronic and acute respiratory illnesses. These services must be provided by a qualified respiratory therapist. Treatment would include the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures, including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel. Your physician would provide a medical order to treat your specified conditions. Prior authorization is required.

Benefit	Description of Covered Services
Nutritional Support	Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition. 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. Prior authorization is required.
Private Duty Nursing	Private duty nursing services are nursing services for Medicaid members who require more individual and continuous nursing care than is available from a certified home health agency (CHHA). Services are provided in the member's home at their permanent or temporary place of residence. Private duty nursing services may be provided by Licensed Home Care Agencies (LCHSAs) or independently practicing Registered Nurses or Licensed Practical Nurse (LPN) who are enrolled with New York State Medicaid. Private duty nursing services require a provider order and prior authorization.
Home Delivered or Congregate Meals	Meals provided to members who are unable to plan, shop for or prepare such meals due to illness, disability or advanced age. Meals may be provided at home or in congregate settings (e.g., senior centers). Prior authorization is required.

Benefit	Description of Covered Services
Adult Day 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). Prior authorization is required.
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. Prior authorization is required.
Social and Environmental Supports	Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, and respite care. Prior authorization is required.
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. Prior authorization is required.

Benefit	Description of Covered Services
Telehealth	Telehealth-delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a member. Telehealth does not include delivery of health care services by means of audio only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring. Prior authorization is not required.
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 authorization.
Emergency Transportation	Transportation provided by an ambulance service, including air ambulance. Emergency transportation will allow members to receive services to treat severe, life-threatening or potentially disabling conditions while member is being transported to a hospital including the emergency room. This includes transportation to a hospital emergency department generated by telephoning " 911".

Covered Behavioral Health (Mental Health and Addiction) Services

Adult Outpatient Mental Health Care

- **Continuing Day Treatment (CDT):** Provides adults with serious mental illness the skills and supports necessary to remain in the community and be more independent. You can attend several days per week, with visits lasting more than an hour.

- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

Adult Outpatient Rehabilitative Mental Health Care

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals who have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

Adult Outpatient Rehabilitative Mental Health And Addiction Services For Members Who Meet Clinical Requirements. These are also known as CORE.

- **Community Oriented Recovery and Empowerment (CORE) Services:** Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer or self-refer to CORE Services.
- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections, finding or keeping a job, starting or returning to school, and using community resources.
- **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment.

- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.
- **Empowerment Services—Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance while learning how to:
  - live with health challenges and be independent,
  - help you make decisions about your own recovery, and
  - find natural supports and resources.

Adult Mental Health Crisis Services

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.
- **Crisis Residential Programs:** A short-term residence that provides 24 hours per day services up to 28 days for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support the return to your community.

Adult Outpatient Addiction Services

- **Opioid Treatment Centers (OTP)** are OASAS-certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

Adult Residential Addiction Services

- **Residential Services** are for people who need 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

Adult Inpatient Addiction Rehabilitation Services

- **State Operated Addiction Treatment Center's (ATC)** provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment service s are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.
- **Inpatient Addiction Rehabilitation** programs can provide you with a safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer care 24 hours a day, 7 days a week, that is always supervised by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.
- **Inpatient Medically Supervised Detox** programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within 24 hours of admission and medical supervision of intoxication and withdrawal conditions.

If you need any immediate mental health support or are experience a crisis, you can call or text 988. You can also chat at 988 at www.988lifeline.org, 24 hours a day, 7 days a week.

Call Member Services at 1-877-891-6447 (TTY: 711) 7 days a week from 8:00 a.m. to 8:00 p.m. if you have any questions about our services.

Benefit Limitations:

- 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 diseases 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 considered a permanent placement provided they are eligible for institutional Medicaid coverage.

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 your community

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

- Giving you information about 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 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 **health.ny.gove/mfp or www.ilny.org**.

Getting Care Outside the Service Area

If you are away from home or 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 8:00 a.m. to 8:00 p.m.

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 providing you with 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 remains 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 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 only cover additional care if:

- 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-POS 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-POS D-SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

- Non-Emergency Medical Transportation
    - Transportation to and from your medical appointments are now available through the Medicaid program directly. Trips are arranged by the New York statewide transportation broker known as Medical Answering Services (MAS). Your provider will need to complete a medical necessity form (Form 2015 or Form 2020) on the MAS portal for ongoing trips. Visit the MAS website at https://www.medanswering.com/ for more information.

  - To arrange your transportation or if you have any questions, call MAS at (844)-666-6270 for downstate counties (Bronx, Brooklyn, New York, Queens, Richmond Nassau, Westchester, Putnam) or at (866)-932-7740 for upstate counties (Orange, Rockland, Dutchess, Sullivan, Ulster).
  - Social Adult Day Care (SADC) centers will provide transportation for members to and from their programs.
- Out-of-network Family Planning services under the direct access provisions
- Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit)
- Certain Mental Health Services, including:
  - o Health Home (HH) and Health Home Plus (HH+) Care Management services
  - o Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
  - o OMH Day Treatment
  - o OASAS Residential Rehabilitation for Youth
  - o Certified Community Behavioral Health Clinics (CCBHC)
  - o OMH Residential Treatment Facility (RTF)
- For MAP enrollees up to the age of 21:
  - o Children and Family Treatment and Support Services (CFTSS)
  - o Children's Home and Community Based Services (HCBS)
- Certain Intellectual Disability and Developmental Disabilities Services, including:
  - o Long-term therapies
  - o Day Treatment
  - o Medicaid Service Coordination
  - o Services received under the Home and Community Based Services Waiver

- Other Medicaid Services:
    - o Directly Observed Therapy for TB (Tuberculosis)
    - o Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria
- Assisted Living Program

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

You must pay for services that are not covered by Elderplan Plus Long-Term Care (HMO-POS 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-POS 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-POS 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 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
55 Water Street, 46th Floor
New York, NY 10041

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 the 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 admissions, SNF admissions/Acute rehabilitation
- Non-emergent ambulance
- Physical Therapy/Comprehensive Outpatient Rehabilitation Facilities (e.g., 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)
- Home Visiting Specialists

Concurrent Review

You can also ask the 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 it. 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, nurse, or 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 workdays 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 workday 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) in this handbook explains 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 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 POS D-SNP) Evidence of Coverage (EOC).

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-POS 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 handbook. 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 **sixty-five (65) 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"**.
  - o 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.)
  - o If your provider tells us that your health requires a fast appeal, we will give you a fast appeal.
  - o 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 **cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **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.)
- You can make the Level 1 Appeal by phone or in writing. To make this appeal in writing, please send to:

Elderplan
Attn: Appeals & Grievance
55 Water Street, 46th Floor
New York, NY 10041

- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.

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 received 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.
    - o 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 Office of Administrative Hearings, 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;
- experimental or investigational;
- 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 **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 workdays) 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 Office of Administrative Hearings reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- The Office of Administrative Hearings 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." You have the right to ask us for a free copy of your case file.
- You have a right to give the Office of Administrative Hearings additional information to support your appeal.
- Reviewers at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal. The Office of Administrative Hearings 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 Office of Administrative Hearings 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 sixty (60) calendar days** of when it gets your appeal. There is a total of 90 days available between the date you request a plan appeal (Level 1) and the date that the Hearing Office decides your Level 2 appeal.
- If the Office of Administrative Hearings 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 41 for information about continuing your benefits during Level 1 Appeals.

The Office of Administrative Hearings will tell you its decision in writing and explain the reasons for it.

- If the Office of Administrative Hearings 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 Office of Administrative Hearings' decision**.
- If the Office of Administrative Hearings 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 Office of Administrative Hearings 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 your Medicare and Medicaid benefits, except Medicare Part D. 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 8:00 a.m. to 8:00 p.m.
- 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:

Elderplan
Attn: Member Services
55 Water Street, 46th Floor
New York, NY 10041

- To file a complaint with the plan by phone, call Member Services at 1-877-891-6447 (TTY: 711), 7 days a week from 8:00 a.m. to 8:00 p.m. If you call us after hours, leave a message. We will call you back the next workday. 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 Office of Administrative Hearings 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 workdays 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.
  - o If you make an appeal by phone, you must follow it up in writing.
  - o After your call, we will send you a form that summarizes your phone appeal.
  - o 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 workdays. 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 workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 workdays 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, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long-term care recipients in the state of New York. ICAN can also assist members with resolution of any issues related to access to care, understanding plan choices, and with filing appeals and complaints.

ICAN Contact Information:

Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor, New York, New York 10017
Web: www.icannys.org | Email: ican@cssny.org
Phone: 1-844-614-8800 (TTY: 711)
9:00 am – 5:00 pm, Monday – Friday

DOH Contact Information

If you are not able to resolve your needs within the plan, you can also contact New York State Department of Health and file a complaint at any time at:

NYS Department of Health
Bureau of Managed Long Term Care
Suite 1620, One Commerce Plaza
99 Washington Avenue
Albany, NY 12210
1-866-712-7197

DFS Contact Information:

You can also contact the New York State Department of Financial Services at:

NYS Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12210
1-800-342-37367

SECTION 15. Disenrollment From Elderplan Plus Long-Term Care (HMO-POS 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.

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Program based on any of the following reasons:

- high utilization of covered medical services, an existing condition, or a change in your health, or
- diminished mental capacity or uncooperative or disruptive behavior due to any special needs, unless the behavior results in you becoming ineligible for the Medicaid Advantage Plus Program.

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 Voluntary Disenroll

You can ask to leave the Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicaid Advantage Plus program at any time for any reason. To request disenrollment, call Elderplan Plus Long-Term Care (HMO-POS 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 disenroll from Elderplan Plus Long-Term Care (HMO-POS 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-based long-term care services are no longer covered by New York's Fee-For-Service Medicaid Program.

You Will Have to Leave the Plan

You will have to leave Elderplan Plus Long-Term Care (HMO-POS D-SNP) Medicaid Advantage Plus Program if you:

- Are no longer enrolled in Elderplan Plus Long-Term Care (HMO-POS 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.
- Permanently move
- 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.
    - o Elderplan shall provide the LDSS or entity designated by the State with the results of its assessment and recommendations regarding continued enrollment or disenrollment within 5 business days of the comprehensive assessment.
- Refuse to complete required reassessment.
- Become incarcerated.

- Join a Home and Community Based Services waiver program, or become a resident of an Office for People with Development Disabilities residential program,
- Become a resident of an Office of Mental health (OMH) or Office of Addiction Services and Supports (OASAS) residential program (that is not a MAP plan covered benefit) for 45 consecutive days or longer.

We Can Ask You to Leave the Plan

We will ask that you leave Elderplan Plus Long-Term Care (HMO-POS 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 services 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 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.

SECTION 16. Rights and Responsibilities

As a member in Elderplan Plus Long-Term Care (HMO-POS 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-POS 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. See contact information on page 54.
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.
17. To seek assistance from Participant Ombudsman program (contact information in Section 14).

Responsibilities of Members

To have the greatest benefit from enrollment in Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) Network Providers for care except in emergency situations.
    - To notify Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP)
    - To appropriately express opinions, concerns and suggestions in the following ways including, but not limited to, your Care Team or through the Elderplan Plus Long-Term Care (HMO-POS 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-POS D-SNP) in maintaining a safe home environment.

- To notify your Care Team at Elderplan Plus Long-Term Care (HMO-POS 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 medical providers
  - any changes in condition that may affect our ability to provide care

SECTION 17. Advance 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 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:

- Living Will - a written statement of your specific health care wishes in the event you become unable to decide yourself.
- Power of Attorney – a legal document where you can grant another person with the authority to make decisions for you if you cannot do so.
- Durable Power of Attorney for Health – a legal document where you can grant another person the authority to make medical decisions for you if you become unable to do so.
- Health Care Proxy – a form that states who your health care agent is. This is someone you trust and choose to make health care decisions for you if you become unable to make your own decisions.

- Do Not Resuscitate Orders – based on your wishes, this document tells health care providers and emergency workers to stop or not begin any cardiopulmonary resuscitation (CPR).
- Medical Orders for Life Sustaining Treatment (MOLST) – a medical order completed by you and your health care provider to indicate your decision to avoid or not receive any treatment.

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 your Care Manager. 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.

Visit our website at **https://www.mjhs.org/our-services/mjhs-hospice-palliative-care/advance-directives/** for more information.

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:

- Information in different formats, including large print, another language or alternative formats such as braille.
- A list of names, business addresses and official positions of the members of Elderplan Plus Long-Term Care (HMO-POS 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-POS 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-POS 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-POS D-SNP)'s Quality Assurance Program.
- A description of the procedures followed by Elderplan Plus Long-Term Care (HMO-POS 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-POS 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-POS 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-POS D-SNP).

- Individual health practitioner affiliations with participating hospitals and other facilities.
- Licensure, certification and accreditation status of participating providers.
- Written application, procedures and minimum qualification requirements for health care providers to be considered by Elderplan Plus Long-Term Care (HMO-POS D-SNP); and/or
- Information concerning the education, facility affiliation, and participation in clinical performance reviews conducted by the Department of Health, of health care professionals who are licensed, registered, or certified under Article 8 of the State Education Law.

Electronic Notice Option

Elderplan Plus Long-Term Care (HMO-POS D-SNP) and our vendors can send you notices about service authorizations, plan appeals, complaints and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices by web portal. You will receive an email and/or text to alert you of notices posted on the web portal. If you choose the email option, you will need an active email address and a web browser with internet access. If you choose the text message option, you will need a mobile phone that access texts and has access to the internet. Please note that standard text messaging and data rates may apply.

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

Online	notices.elderplan.org
Mail	Elderplan c/o Command Direct, PO Box 18023, Hauppauge, NY 11788
Phone	1-877-891-6447

When you contact us, you must tell us how you want to receive notices and give us your contact information (which may include your name, date of birth, Elderplan member ID number, mobile phone number, and email address). Elderplan Plus Long-Term Care (HMO-POS D-SNP) will let you know by mail that you have asked to get notices electronically.

For further instructions or if you require technical assistance with using the electronic methods offered by Elderplan, please reach out to our Member Services department at 1-877-891-6447 (TTY: 711), 8 a.m. – 8 p.m., 7 days a week. Or visit www.elderplan.org for more information.

Disclaimer Information:

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1, 2025.

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

Eligible beneficiaries can enroll at any time. Contact Elderplan Plus Long-Term Care (HMO-POS 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 8:00 a.m. to 8:00 p.m. 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 果您需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。

Elderplan Plus Long-Term Care Member Services

Method	Member Services – Contact Information
CALL	1-877-891-6447 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. 8:00 a.m. to 8:00 p.m., 7 days a week
FAX	718-759-3643
WRITE	Elderplan, Inc. Attn: Member Services 55 Water Street, 46th Floor New York, NY 10041
WEBSITE	**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	**aging.ny.gov/programs/medicare-and-health-insurance**

Elderplan, Inc. Notice of Privacy Practices

EFFECTIVE DATE: 9/1/2020

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice summarizes the privacy practices of Elderplan Inc. (the "Plan"), its workforce, medical staff, and other health professionals. We may share protected health information ("PHI" or "Health Information") about you with each other for purposes described in this notice, including for the Plan's administrative activities.

The Plan is committed to safeguarding the privacy of our members' PHI. PHI is information which:

(1) identifies you (or can reasonably be used to identify you); and (2) relates to your physical or mental health or condition, the provision of health care to you or the payment for that care.

OUR OBLIGATIONS

- We are required by law to maintain the privacy and security of your PHI.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

The following categories describe different ways that we may use and disclose Health Information. Not every use or disclosure permitted in a category is listed below, but the categories provide examples of the uses and disclosures permitted by law.

Payment. We may use and disclose Health Information processes and pay claims submitted to us by you or by physicians, hospitals and other health care providers for services provided to you. For example, other payment purposes may include the use of Health Information to determine eligibility for benefits, coordination of benefits, collection of premiums, and medical necessity. We may also share your information with another health plan that provides or has provided coverage to you for payment purposes or for detecting or preventing health care fraud and abuse.

Health Care Operations. We may use and disclose Health Information for health care operations, which are administrative activities involved in operating the Plan. For example, we may use Health Information to operate and manage our business activities related to providing and managing your health care coverage or resolving grievances.

Treatment. We may disclose your Health Information with your health care provider (pharmacies, physicians, hospitals, etc.) to help them provide care to you.

For example, if you are in the hospital, we may disclose information sent to us by your physician.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose Health Information to contact you as a reminder that you have an appointment/visit with us or your health care provider. We also may use and disclose Health Information to tell you about treatment options, alternatives, health-related benefits, or services that may be of interest to you.

By providing us with certain information, you expressly agree that the Plan and its business associates can use certain information (such as your home/work/cellular telephone number and your email), to contact you about various matters, such as follow up appointments, collection of amounts owed and other operational matters. You agree you may be contacted through the information you have provided and by use of pre-recorded/artificial voice messages and use of an automatic/predictive dialing system.

Individuals Involved in Your Care or Payment for Your Care. We may disclose Health Information to a person, such as a family member or friend, who is involved in your medical care or helps pay for your care. We also may notify such individuals about your location or general condition, or disclose such information to an entity assisting in a disaster relief effort. In these cases, we will only share the Health Information that is directly relevant to the person's involvement in your health care or payment related to your health care.

Personal Representatives. We may disclose your Health Information to your personal representative, if any. A personal representative has legal authority to act on your behalf in making decisions related to your health care or care payment. For example, we may disclose your Health Information to a durable power of attorney or legal guardian.

Research. Under certain circumstances, as an organization that performs research, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all members who received one medication or treatment to those who received another, for

the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. We also may permit researchers to look at records to help them identify members who may be included in their research project or for other similar purposes.

Fundraising Activities. We may use or disclose your demographic information (e.g., name, address, telephone numbers and other contact information), the dates of health care provided to you, your health care status, the department and physician(s) who provided you services, and your treatment outcome information in contacting you in an effort to raise funds in support of the Plan and other non profit entities with whom we are conducting a joint fundraising project. We may also disclose your Health Information to a related foundation or to our business associates so that they may contact you to raise funds for us. If we do use or disclose your Health Information for fundraising purposes, you will be informed of your rights to opt-out of receiving further fundraising communications.

SPECIAL CIRCUMSTANCES

In addition to the above, we may use and disclose Health Information in the following special circumstances. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent or lessen a serious threat to your health or safety, or the health or safety of the public or another person. Any disclosure, however, will be to someone who we believe may be able to help prevent the threat.

Business Associates. We may disclose Health Information to the business associates that we engage to provide services on our behalf if the information is needed for such services. For example, we may use another company to perform billing services on our behalf. Our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract with them.

Organ and Tissue Donation. If you are an organ donor, we may release Health Information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may disclose Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; track certain products and monitor their use and effectiveness; if authorized by law, notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and conduct medical surveillance of our facilities in certain limited circumstances concerning workplace illness or injury. We also may release Health Information to an appropriate government authority if we believe a member has been the victim of abuse, neglect or domestic violence; however, we will only release this information if the member agrees or when we are required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure of our facilities and providers. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Legal Actions. We may disclose Health Information in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process by someone else involved in a legal action, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official as follows:

(1) in response to a court order, subpoena, warrant, summons or similar process;

(2) limited information to identify or locate a suspect, fugitive, material witness or missing person; (3) about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about evidence of criminal conduct on our premises; and (6) in emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. In some circumstances this may be necessary, for example, to determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates or Individuals in Custody. In the case of inmates of a correctional institution or that are under the custody of a law enforcement official, we may release Health Information to the appropriate correctional institution or law enforcement official. This release would be made only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Additional Restrictions on Use and Disclosure: Some kinds of Health Information including, but not limited to, information related to alcohol and drug abuse, mental health treatment, genetic, and confidential HIV-related information require written authorization prior to disclosure and are subject to separate special privacy protections under the laws of the State of New York or other federal laws, so that portions of this notice may not apply.

In the case of genetic information, we will not use or share your genetic information for underwriting purposes.

If a use or sharing of Health Information described above in this Notice is prohibited or otherwise limited by other laws that apply to us, our policy is to meet the requirements of the more stringent law.

USES AND DISCLOSURE REQUIRING WRITTEN AUTHORIZATION

In situations other than those described above, we will ask for your written authorization before using or disclosing personal information about you. For example, we will get your authorization:

1) for marketing purposes that are unrelated to your benefit plan,

2) before disclosing any psychotherapy notes,

3) related to the sale of your Health Information, and

4) for other reasons as required by law. For example, state law further requires us to ask for your written authorization before using or disclosing information relating to HIV/AIDS, substance abuse or mental health information.

You have the right to revoke any such authorizations, except in limited circumstance such as if we have taken action in reliance on your authorization.

YOUR RIGHTS

You have the following rights, subject to certain limitations, regarding Health Information that we maintain about you—all requests must be made IN WRITING:

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information that we use or disclose for treatment, payment or health care operations. You have the right to request a limit on the Health Information that we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request, and we may say "no" if it would affect your care. If we agree to your request, we will comply with your request unless we need to use the information in certain emergency treatment situations.

Right to Request Confidential Communications. If you clearly state that the disclosure of all or part of your Health Information could endanger you, you have the right to request that we communicate with you in a certain manner or at a certain location other than through our usual means of communication. For example, you can ask that we contact you only by sending mail to a P.O. Box rather than your home address or you may wish to receive calls at an alternate phone number. Your request must be in writing and specify how or where you wish to be contacted.

Right to Inspect and Copy. You have the right to inspect and receive a copy of your Health Information that we have in our records that is used to make decisions about your enrollment, care or payment for your care, including information kept

in an electronic health record. If you want to review or receive a copy of these records, you must make the request in writing. We may charge you a reasonable fee for the cost of copying and mailing the records. We may deny your access to certain information. If we do so, we will give you the reason in writing. We will also explain how you may appeal the decision.

Please note that there may be a charge for paper or electronic copies of your records.

Right to Amend. If you feel the Health Information that we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is maintained by or for us. You must tell us the reason for your request.

We may deny your request for an amendment to your record. We may do this if your request is not in writing or does not include a reason to support the request. We also may deny your request if you ask us to amend information that:

- we did not create;
- is not part of the records used to make decisions about you;
- is not part of the information which you are permitted to inspect and to receive a copy; or
- is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of Health Information that we made for a six-year period. The accounting will only include disclosures that were not made for treatment, payment, health care operations, to you, pursuant to authorization, or for "special circumstances" as outlined in this notice. You are entitled to one

Accounting of Disclosures at no charge. Subsequent requests within a twelve month period may be subject to a fee.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at any time from the Plan's website: **elderplan.org/**

HOW TO EXERCISE YOUR RIGHTS

To exercise any of your rights described in this notice, other than to obtain a paper copy of this notice, you must contact the Plan.

Elderplan
Attention: Regulatory Compliance
55 Water Street, 46th Floor
New York, NY 10041
1-800-353-3765

BREACH NOTIFICATION

We will keep your Health Information private and secure as required by law. If there is a breach (as defined by law) of any of your Health Information, then we will notify you within 60 days following the discovery of the breach, unless a delay in notification is requested by law enforcement.

ELECTRONIC HEALTH INFORMATION EXCHANGE

The Plan may participate in various systems of electronic exchange of Health Information with other healthcare providers, health information exchange networks and health plans. Your Health Information maintained by the Plan may be accessed by other providers, health information exchange networks and health plans for the purposes of treatment, payment, or health care operations. In addition, the Plan may access your Health Information maintained by other providers, health information exchange networks and health plans for treatment, payment or health care operation purposes—but only with your consent.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for Health Information that we already have as well as any information we receive in the future. The new notice will be available upon request, on our website, and we will mail a copy to you. The notice will contain the effective date on the first page, in the top left-hand corner.

COMPLAINTS AND QUESTIONS

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Office at the address listed below. All complaints must be made in writing.

Elderplan
Attention: Regulatory Compliance
55 Water Street, 46th Floor
New York, NY 10041

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **hhs.gov/ocr/privacy/hipaa/complaints/**.

We will not retaliate against you if you exercise your right to file a complaint.

If you have any questions about this notice, please contact 1-855-395-9169 (TTY: 711)

Elderplan, Inc.
Notice of Nondiscrimination—Discrimination is Against the Law

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 grievance with:

Civil Rights Coordinator
55 Water Street, 46th Floor
New York, NY 10041
Phone: 1-877-326-9978, TTY: 711
Fax: 1-718-759-3643

You may file a grievance in person or by mail, phone or fax. If you need help filing a grievance, 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 **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 **hhs.gov/ocr/office/file/index.html**.

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-891-6447 (TTY: 711). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-891-6447 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Simplified: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电1-877-891-6447 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Traditional: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-877-891-6447 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-891-6447 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-891-6447 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-891-6447 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-891-6447 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-891-6447 (TTY: 711) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-877-891-6447 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لديناً. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-877-891-6447 (711:TTY). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-891-6447 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-891-6447 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-891-6447 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-891-6447 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-891-6447 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Albanian: Ne ofrojmë shërbime interpretimi pa pagesë për t'ju përgjigjur çdo lloj pyetjeje që mund të keni rreth planit tonë të shëndetit ose të mjekimit. Për t'u lidhur me një interpret, telefononi në 1-877-891-6447 (TTY: 711). Një shqip folës mund t'ju ndiHMO-POSjë. Ky shërbim është pa pagesë.

Bengali: আমাদরে স্বাস্থ্য বা ওষুধপত্র বষিয়ক পরকিল্পনা সম্পর্কতি আপনার যে কোনো প্রশ্নরে উত্তর দওেয়ার জন্য আমাদরে বনিামূল্যে দোভাষী পরষিবো রয়ছে। একজন দোভাষী পতে, আমাদরে কবেল 1-877-891-6447 (TTY: 711) নম্বরে কল করুন। বাংলা বলতে পারনে এমন কউে আপনাকে সাহায্য করতে পারবনে। পরষিবোর্টি বনিামূল্যে।

Greek: Διαθέτουμε υπηρεσία δωρεάν διερμηνείας προκειμένου να απαντούμε σε οποιεσδήποτε απορίες σας σχετικά με το πρόγραμμα υγείας ή φαρμάκων που προσφέρουμε. Προκειμένου να χρησιμοποιήσετε την υπηρεσία διερμηνείας, επικοινωνήστε μαζί μας καλώντας το 1-877-891- 6447 (TTY: 711). Θα λάβετε βοήθεια από ένα άτομο που μιλά ελληνικά.Αυτή είναι μια υπηρεσία που παρέχεται δωρεάν.

Yiddish: עכלעוו ייס ורעפטנע וצ סעסיוורעס רעשטעמלאד עטסיזמוא ובאה רימ ואלפ גארד רעדא טלעה רעזנוא וגעוו ובאה ריליגעמ טנעק ריא סאוו סעגארפ .וצ רעשטעמלאד א ועמוקאב ,רייוּ זנוא טפור (TTY:711) 1-877-891-6447 . רענייא סיוורעס עטסיזמוא וא זיא סאד .ופלעה רייא ועק רארפש/שידיא טדער סאוו.

Urdu: ہماری صحت ای اود کے پالان کے باروے میں آپ کے کسی بھی سوال کا جواب دینے کے لیے ہمارے پاس مفت مترجم کی خدمات موجود ہیں۔ مترجم حاصل کرنے کے لیے، ہمیں بس 1-877-891-6447 (TTY:711) پر کال کریں۔ اردو بولنے والا کوئی شخص آپ کی مدد کر سکتا ہے۔ یہ ایک مفت خدمت