

TABLE OF CONTENTS

Welcome to Hamaspik CHOICE, Inc.	2
Benefits of Joining Hamaspik CHOICE, Inc.....	3
Eligibility and Effective Dates of Coverage.....	4
The Assessment Process.....	6
Enrollment.....	7
Service Benefit Package	7
Accessing Services.....	15
Selecting Providers.....	18
Service Authorizations.....	21
Termination of Coverage.....	22
Medicaid Spend down.....	24
Veteran Protection.....	24
Rights and Responsibilities.....	25
Member Grievance and Appeal Process.....	27
Money Follows the Person/Open Doors.....	41
Additional Information Available Upon Request.....	42
Certain Definitions.....	42
Notice of Privacy Practices.....	41
Advanced Directives.....	51

Welcome to Hamaspik CHOICE, Inc.

Hamaspik CHOICE, Inc. is delighted that you have chosen to join our plan!

Hamaspik CHOICE, Inc. is a Managed Long Term Care Plan designed to help you live as independently as possible by offering a full range of long term care and health-related services. We are committed to high quality, compassionate care that is appropriate to you and your particular situation.

Hamaspik CHOICE Inc. is a Managed Long Term Care Plan authorized by New York State. It bears the financial risk and legal responsibility under contract with New York State and its enrollment agreements with members.

To enroll in Hamaspik CHOICE, Inc., you must be at least 18 years old and live in one of the following counties:

- Dutchess
- Orange
- Putnam
- Rockland
- Sullivan
- Ulster

You must be Medicaid eligible. (Hamaspik CHOICE, Inc. staff can help you determine whether you are eligible), and assessed as needing community based long term care services for more than 120 days.

This handbook is intended to serve as a reference for you, so please save it. We have defined some of the terms used in this handbook in the section called "Definitions".

This handbook is available in other languages. For members who require it, we provide a language interpretation service, which may be utilized to orally translate materials to you over the phone. For members with visual impairments, Hamaspik Choice staff members are available to read this member handbook.

We are always happy to answer any questions or comments you may have. Our toll-free telephone number is 855-552-4642 (855-55-CHOICE), TTY 855-854-4030.

Our address, should you wish to write us, is:

58 Route 59, Suite 1, Monsey, NY 10952.

Benefits of Joining Hamaspik CHOICE, Inc.

If you enroll in Hamaspik CHOICE, Inc., you may speak with a health care professional 24 hours a day, 7 days a week, and 365 days a year. Our health professionals monitor changes in your health status, provide care and education, and encourage self-help. As a member of Hamaspik CHOICE, Inc., you participate in developing your Person Centered Service Plan (PCSP). Your PCSP includes covered services that are medically necessary and non-covered services that you may be receiving, to assure full coordination of services you require and are receiving. Covered services are paid for through Hamaspik CHOICE, Inc. by Medicaid. Medicaid and/or Medicare will still pay for appropriate medically necessary services not covered by Hamaspik CHOICE, Inc. Except for certain pre-approved covered services, all covered services require prior Hamaspik CHOICE, Inc. approval. You do not need Hamaspik CHOICE, Inc. approval for non-covered services, although we will work with you and with your providers to arrange both covered and non-covered services.

Hamaspik CHOICE, Inc. will provide health education to Enrollees on an on-going basis through methods such as posting information on the Hamaspik CHOICE, Inc. web site at www.hamaspikchoice.org, upon Enrollee request, or individual counseling on preventive health and public health topics, such as:

- Injury prevention
- Domestic violence
- HIV/AIDS, including availability of HIV testing and sterile needles and syringes
- STDs, including how to access confidential STD services
- Smoking cessation
- Asthma
- Immunization
- Mental health services
- Diabetes
- Screening for cancer
- Chemical dependence

- Physical fitness and nutrition
- Cardiovascular disease and hypertension
- Dental care, including importance of preventive services such as dental sealants; and
- Screening for Hepatitis C for individuals born between 1945 and 1965.

Your PCSP is designated to address your individual needs. Hamaspik CHOICE, Inc.'s staff has extensive experience in planning and providing services for individuals with long term disabilities and various medical conditions, including conditions that require specialized knowledge, equipment and accommodations. Your PCSP is a written plan of the services you need, how often you need them, and for how long. It includes services covered by Hamaspik CHOICE, Inc. that are medically necessary and non-covered services. Your PCSP is based on our assessment of your health, long term care needs, and the orders and recommendations of your physician(s) and upon your personal preferences. Your PCSP identifies, evaluates and helps you manage physical, emotional and social factors that affect your well-being. Your PCSP is reviewed with you and with your physician as needed, at least every six months and more often if your health status changes. As your needs change, your PCSP will change to meet those needs.

We will work with your physician to coordinate your care.

When you join, you will be assigned a Care Manager. The care manager is responsible for coordinating and making sure you receive services as indicated in your PCSP. The care manager provides support and assistance in making sure your care is timely and appropriate to your needs as specified in your PCSP. Your care manager will communicate with others involved in your care, as appropriate, including you, your family, your physician and your service providers.

Eligibility and Effective Dates of Coverage

Enrollment in Hamaspik CHOICE, Inc. is voluntary. You should make an informed decision to enroll and you may choose to end your membership at any time. To be able to enroll you must meet the following requirements:

1. Age requirements:
 - In mandatory counties:

- Dual eligible, age 21 and older must enroll in a plan in order to receive CBLTC services
 - The following individuals may voluntarily enroll in a Plan
 - Dual eligible individuals age 18-20
 - Non-dual eligible individuals, age 18 and older
 - In non-mandatory counties, individuals age 18 and older may voluntarily enroll.
- 2. Reside in Dutchess, Orange, Putnam, Rockland, Sullivan or Ulster County
- 3. Be Eligible for Medicaid as determined by your Local Department of Social Services
- 4. Be capable, at the time of enrollment, of returning to or remaining in your home, community or nursing home without jeopardy to your health and safety
- 5. Be in need of long term care services for more than 120 days from the date of enrollment. Long term care services include Nursing services, therapies, home health or personal care services, adult day health care, private duty nursing or CDPAS.

If you are an inpatient in a hospital or a resident of an Office of Mental Health (OMH), Office of Alcoholism and Substance Abuse Services (OASAS), or Office for People with Developmental Disabilities (OPWDD) facility, or if you are enrolled in another Medicaid managed long term care plan, Home and Community-Based Services (HCBS) waiver program, OPWDD Day Treatment program, or receiving services from hospice, we cannot enroll you until you are discharged or disenrolled from that program. ¶

Enrollment or denial of enrollment in our program must be approved by the LDSS or New York Medicaid Choice.

To remain in Hamaspik CHOICE, Inc., you must continue to live in the service area.

You may be denied enrollment for one or more of the following reasons:

- (i) You do not meet one or more of the eligibility requirements, as listed above;
- (ii) You have previously been involuntarily disenrolled from Hamaspik CHOICE, Inc. and the circumstances surrounding your disenrollment have not changed.

If you are transitioning from a Medicaid community based long-term program, you will continue to receive services under your pre-existing service plan for at

least 90 days after enrollment. Your services will be authorized at the same level, scope and amount as you received through Medicaid.ca

If, after 90 days, Hamaspik Choice decides to change the services authorized, you will receive a notice of action, which articulates your right to file an appeal, and your right to a fair hearing and external appeal. You will have the right to continue receiving the same services when you request an appeal or fair hearing.

Nursing Home Transition

All dual eligible persons 21 years old and over seeking or referred for permanent nursing home placement must be enrolled in a Managed Long Term Care Plan.

Individuals who are not enrolled in an MLTCP who are in need of permanent Nursing Home Care shall obtain a long term Medicaid determination from the Local Department of Social Services, prior to enrollment in an MLTCP.

Dual eligible individuals who are 21 years old or older and have been determined eligible for Long Term Placement in a nursing home are allowed sixty (60) days to select an MLTCP for enrollment, individuals who do not enroll in an MLTCP within the allotted time will be auto-assigned to an MLTCP which contracts with the nursing home where the individual is currently placed.

Individuals who wish to enroll in Hamaspik Choice will be referred for a Conflict Free Evaluation that will be conducted by New York Medicaid Choice to determine eligibility for Community Based Long Term Care, prior to Hamaspik Choice's initial assessment which will be conducted within 30 days of first contact by an individual requesting enrollment, or receipt of a referral.

If Hamaspik Choice does not have a nursing home in-network to meet your needs, we will authorize out of network placement.

The Assessment Process

There are several steps to enrolling in Hamaspik CHOICE, Inc. The process includes you, your family, your physician, NYS Medicaid Choice and Hamaspik CHOICE, Inc. If you begin the process and change your mind you may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment. The process includes:

- Anyone may contact us - you, your family, a friend, a medical provider - to notify us of your interest in Hamaspik CHOICE, Inc.

- A Hamaspik CHOICE, Inc. staff member will contact you to explain our program.
- Hamaspik CHOICE, Inc. complies with the Conflict Free Evaluation and Enrollment Center (CFEEC) enrollment protocols. A Conflict Free Evaluation will be conducted by New York Medicaid Choice to determine eligibility for Community Based Long Term Care, prior to Hamaspik Choice's initial assessment. This does not apply to individuals transferring from another MLTC plan or individuals already receiving CBLTC services through FFS.
- If you are interested and are eligible for benefits under Medicaid, Hamaspik CHOICE, Inc. will conduct an initial assessment for MLTC eligibility within thirty days of the first contact to the plan requesting enrollment. This assessment will be performed by a Registered Nurse in your home or Nursing Home.
- Together with your input, a PCSP to meet your health care needs will be designed.
- Your Care Manager may contact your physician to discuss your PCSP if necessary.

Enrollment

If you decide to join Hamaspik CHOICE, Inc., you will sign an Enrollment Agreement. During the enrollment process, we will explain how to access services and give you a list of Hamaspik CHOICE, Inc. network providers. You will also receive a Hamaspik CHOICE, Inc. identification card. Remember to keep any regular Medicaid, Medicare and third party insurance cards, too, to use for services not covered by Hamaspik CHOICE, Inc. that may be covered by these other insurance programs. Your enrollment must be approved by New York Medicaid Choice, LDSS or other entity as designated by the NYS DOH.

Effective Dates of Enrollment

If you are assessed prior to the 20th of the month, and your enrollment is approved by NY Medicaid Choice or entity designated by the DOH, your enrollment becomes effective on the first of the following month.

Service Benefit Package

Hamaspik CHOICE, Inc. pays for the health and health-related services listed below. The following services are provided as authorized in your PCSP as medically necessary for you. This means that the service must be necessary to prevent, diagnose, correct or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity or threatens some significant handicap.

Care Management is provided directly through Hamaspik Choice.

The following services are provided through contracted providers:

- Adult Day Health Care
- Audiology/Hearing Aids
- Consumer Directed Personal Assistances Services
- Dentistry
- Durable Medical Equipment
- Home Care (Nursing, home health aide, physical therapy, occupational therapy, speech pathology, medial social services)
- Home Delivered or Congregate meals
- Non-emergency transportation
- Nursing Home Care
- Nutrition
- Optometry/Eye Glasses
- Personal Care
- Personal Emergency Response System
- Podiatry
- Rehabilitation Therapy (Physical Therapy, Occupational, Therapy, Speech Therapy or other therapies provided in a setting other than a home. Medicaid covered outpatient PT, OT, and SLP services are limited to 20 visits per year, per therapy.
- Respiratory Therapy
- Private Duty Nursing
- Social Day Care
- Social and Environmental Supports

All services listed above require prior approval, except for the following services:

- Audiology –routine examination once per year
- Care Management
- Dental care – routine dental examinations up to twice yearly and emergency dental care

- Optometry exams and eyeglasses – routine optometry examination which includes refraction, and prescription lenses for eyeglass frames at Medicaid rates once every two years
- Podiatry consultation once per year for those members whose condition requires it

More about the services and benefits of Hamaspik CHOICE, Inc. Inc.

Adult Day Health Care: Adult Day Health Care services are provided in a residential health care facility or State-approved site. The services provided at an adult day health care may include: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical and other ancillary services.

Care Management – Care management services are provided to all members enrolled in Hamaspik CHOICE, Inc. Care Management is a process that assists you in accessing necessary services as identified in your PCSP. It also provides referral and coordination of other services in support of the PCSP. Care management services will assist you in obtaining needed medical, social, educational, psychosocial, financial and other services in support of the PCSP irrespective of whether the needed services are covered under Hamaspik CHOICE, Inc.

Consumer Directed Personal Assistance Services (CDPAS)- the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of a consumer or the consumer’s designated representative. To participate in the consumer directed personal assistance services, you must meet the following eligibility requirements:

- Have a stable medical condition;
- Be self-directing or, if non self-directing, have a designated representative;
- Be willing and able to fulfill the member’s responsibilities or have a designated representative who is willing and able to fulfill such responsibilities; and
- Participate as needed, or have a designated representative who so participates, in the required assessment and reassessment processes

Any restriction, reduction, suspension or termination of authorized CDPAS, or denial of a request to change CDPAS, is considered an adverse determination.

You may file an appeal pursuant to 42 CFR part 438, and you may request a fair hearing or external appeal upon a Final Determination.

Dental Services: Your Hamaspik CHOICE, Inc. Care Manager can help you with selecting a dentist or making an appointment, if you wish.

- Hamaspik CHOICE, Inc. is contracted with the DentaQuest network for dental services
- With the help of your care manager, you may choose a provider in your area that is contracted with Hamaspik CHOICE, Inc. to provide services to you
- When making appointments, inform the office that Hamaspik CHOICE, Inc. is your managed long term care plan (MLTCP)
- Bring your Hamaspik CHOICE, Inc. ID card to appointment
- No prior approval is necessary for routine dental examinations up to twice yearly and emergency dental care
- You should never be asked to pay out of pocket for any costs associated with your care. Please let your care manager know if you are *ever* asked to make payments to a provider. Your costs should be *fully* covered by Hamaspik CHOICE, Inc.

Durable Medical Equipment (DME): Hamaspik CHOICE, Inc. coordinates the provision of durable medical equipment (DME). DME describes devices and equipment that are ordered by a practitioner for use in the home and are for the treatment of a specific medical condition. DME has the following characteristics:

1. Can withstand repeated use for a protracted period of time
2. Is primarily and customarily used for medical purposes
3. Is generally not useful in the absence of an illness or injury; and
4. Is not usually fitted, designed or fashioned for a particular individuals' use.

Medical/Surgical Supplies, Enteral* and Parenteral Formula (Hearing Aid Batteries, Prosthetics, Orthotics, Orthopedic Footwear and Respiratory therapy including oxygen.

- **Medical and Surgical Supplies:** Hamaspik CHOICE, Inc. will coordinate with your health care professionals on required medical and surgical supplies. These are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear that have been ordered by a practitioner in the

treatment of a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value.

- **Oxygen and Respiratory Therapy:** Hamaspik CHOICE, Inc. will ensure these services are provided by a qualified respiratory therapist.
- **Prosthetics and Orthotics:** Hamaspik CHOICE, Inc. will coordinate the provision of prosthetic appliances and devices. Prosthetic appliances and devices are devices that replace any missing part of the body. Orthotic appliances and devices are devices used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

*Per Medicaid guidelines, coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following three conditions: 1) individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube; 2) individuals with rare inborn metabolic disorders; and 3) children up to age 21 who require liquid oral enteral nutritional formula when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be absorbed or metabolized. 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.

Eye Exams and Glasses: Hamaspik CHOICE, Inc. is contracted with the EyeQuest networks for vision services including optometry services such as eye exams and eye glasses.

- With the help of your care manager, you may choose a provider in your area that is contracted with Hamaspik CHOICE, Inc. to provide services to you
- When making appointments, inform the office that Hamaspik CHOICE, Inc. is your managed long term care plan (MLTCP)
- Bring your Hamaspik CHOICE, Inc. ID card to all appointments
- You should never be asked to pay out of pocket for any costs associated with your care. Please let your nurse care manager know if you are *ever*

asked to make payments to a provider. Your costs will be *fully* covered by Hamaspik CHOICE, Inc.

Hearing Exams and Hearing Aids: Hearing exams and hearing aids are provided by audiologists. You may visit an audiologist for a routine hearing exam once a year without an authorization. However, if you think you may need a hearing exam, kindly consult with your care manager. We may ask you to see your doctor first, in order to be sure that another health problem is not affecting your ability to hear.

- If you require an evaluation for hearing aids, you must obtain a referral from your doctor prior to receiving the evaluation
- If you need hearing aids or any other audiology services, please speak to your care manager about obtaining authorization for those services.
- Products included with hearing aids:
 - Hearing aids;
 - Ear molds;
 - Batteries;
 - Special fittings; and
 - Replacement parts.

Home Delivered Meals: Hamaspik CHOICE, Inc. can authorize home-delivered or congregate meals provided in accordance with your PCSP.

Home Health Care Services: Hamaspik CHOICE, Inc. will coordinate the provision of services, which may include care from nurses, social workers, nutritionists, physical therapists, occupational therapists and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health.

Non-Emergency Transportation: Upon request, Hamaspik CHOICE, Inc. will arrange and pay for your non-emergency medical transportation services. Services will be provided by ambulance, ambulette or car services depending on your needs. Following, please see important instructions for requesting transportation:

- Transportation provided by Hamaspik Choice is for Non-Emergent medical appointments. If you are ill and need to go to the hospital, please call 911 immediately.

- All requests for transportation must be made at least 2 business days in advance
- When calling to request transportation, kindly have the doctor's name, specialty and phone number available. We will need this information to schedule your trip.
- Confirmation of appointment will be made by our member services department by calling the service location to verify your appointment.
- Please call our transportation department with any changes made to your appointment time/date
- We try to accommodate requests for specific transportation vendors; accommodation is always based on vendor availability
- If you need to see a specialist out of county, your local PCP will need to complete an *Out of County Form*. The *Out of County Form* will specify the reason for which it is necessary for you to travel out of county. Requests for out of county trips should be made at least 10 days in advance.
- To schedule your trip, please call only during business hours Mon-Fri 9AM-5PM
- You can also schedule your transportation online on our website www.hamaspikchoice.org

Nursing Home Care: There may be times when Hamaspik CHOICE, Inc., in consultation with you, your family and your physicians determines that it is necessary for you to stay in a nursing home. If this occurs, your Care Manager will help arrange for you to enter a nursing home in a semi-private room. Private rooms are covered only if medically necessary. Hamaspik CHOICE, Inc. does not cover non-medical items such as telephone charges or television rental. If you should require permanent placement in a nursing facility, your Medicaid eligibility will be converted from “community” to “institutional”. If the Local Department of Social Services (LDSS) determines that you are not eligible for institutional coverage, Hamaspik CHOICE, Inc. is required to initiate an involuntary disenrollment.

Nutritional Services: Hamaspik CHOICE, Inc.'s in-network nutritionists can assess your dietary needs to ensure that your diet meets your needs.

Personal Care: Hamaspik CHOICE, Inc. will coordinate the provision of personal care and help you with such activities as personal hygiene, dressing

and eating, and home-environment support as determined by an assessment of your needs.

Personal Emergency Response System (PERS): PERS enables you to call for assistance in an emergency without having to reach for a telephone.

Private Duty Nursing (PDN): Hamaspik CHOICE, Inc., will coordinate PDN services to enrollees at their permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders.

Rehabilitation Therapy: Hamaspik CHOICE, Inc. Outpatient Rehabilitation services may be provided at outpatient locations, based on your needs. These services include: Physical Therapy, Occupational Therapy, and Speech-Language Pathology which are rehabilitation services, occupational therapy, or speech language pathology for the purpose of maximum reduction of physical or mental disability and restoration to your best functional level.

Podiatry/ Foot Care: Foot care is provided by licensed podiatrists listed in the Hamaspik CHOICE, Inc. Provider Network. 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 may be covered if deemed necessary by Hamaspik CHOICE, Inc.'s clinical department. No prior approval or authorization is necessary for podiatry consultation once per year for those members whose condition requires it.

Social and Environmental Supports: Social and environmental supports include but are not limited to: respite care, home maintenance tasks, chore services, pest control and housing modifications to improve safety.

Social Day Care: Social day care is a structured program that provides you with socialization, supervision, monitoring and nutrition in a protective setting. You may also receive services such as enhancement of daily living skills, personal care, transportation and caregiver assistance.

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 an Enrollee. Telehealth provider means: physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation.

Paying Providers for Covered Services

Hamaspik CHOICE, Inc. is responsible for paying for approved covered services. You are not responsible for payment for covered services, as long as they are authorized in your PCSP. Please see the Service Benefit Package section of this document to find out if a specific service requires prior approval. If you do receive a bill for covered services, please let your care manager know as soon as possible, so that we may promptly correct this error.

Also, if you have third party health insurance, please let us know so that we can coordinate your benefits for covered services.

Accessing Services

You can access Hamaspik CHOICE, Inc. 24 hours a day, 7 days a week, and 365 days a year by calling (855) 552-4642 at any time. Your PCSP specifies the services you will receive. Hamaspik CHOICE, Inc. will also coordinate the services you require, whether or not they are covered services.

While you are not required to do so, Hamaspik CHOICE, Inc. requests that you notify us of any non-covered service you are receiving within two business days of receiving the service, so that it can be included in your PCSP. If we are notified at least 48 hours in advance, we can arrange appropriate transportation to and from the service provider and ensure seamless delivery of services.

To Request a Change in Your Person Centered Service Plan (PCSP) for Covered Services

If you want to change your PCSP, such as the days or times you are receiving a service, or if you feel you need a service that is not currently in your PCSP, you should talk about this with your Care Manager during regular business hours, Monday through Friday between 9:00 am and 5:00 pm at 855-55-CHOICE (855-552-4642). You may also call after hours and your request will be given to your Care Manager on the next business day. Your Care Manager will consult with your physician as necessary to assure that you receive medically necessary services. If we are in agreement with your request, we will change your PCSP to reflect this decision.

If you are unhappy with a provider's service delivery or access to service, you may use the internal grievance and appeals process outlined below in the section titled Member Grievance and Appeal Process.

There are some covered services that do not require prior authorization. These pre-approved services are routine dental care and foot care (podiatry), optometry and audiology exams as detailed above. If you give us advance notification of receipt of these services, we can arrange your transportation. Regardless, we request that you let us know of receipt of the services within two business days of receipt of the service so that it can be included in your PCSP.

Except when no prior approval is required, if a covered service is obtained without a prior Hamaspik CHOICE, Inc. approval, neither Medicaid nor Hamaspik CHOICE, Inc. will be responsible for the payment. It is very important that you discuss with your Care Manager all services you think are needed in your PCSP.

Urgent Care

If you need urgent care, please call your physician. Urgent care is any service that is medically necessary in order to prevent a serious deterioration in your health resulting from an unforeseen illness or injury, when you must be seen sooner than a routine medical visit can be scheduled.

Let us know as soon as possible that you have required urgent care so we can make any necessary changes to your PCSP.

Emergency Care

Emergency Services refers to medically necessary services required to evaluate and stabilize an emergency medical condition. An emergency condition means that you have a medical or behavioral condition, the onset of which is sudden,

that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention could: (1) result in placing your health in serious jeopardy, or, in the case of a behavioral condition, place the health of you or others in serious jeopardy; (2) seriously impair your bodily functions; (3) result in serious dysfunction of any body organ or part of you; or (4) seriously disfigure you.

You are not required to get prior approval from Hamaspik CHOICE, Inc. for treatment of emergency medical conditions. If you require Emergency Services, please call 911. Listen to the questions carefully, answer their questions and follow instructions carefully. If the dispatcher determines that you have a medical emergency, they will arrange an ambulance to transport you to the nearest hospital emergency room.

It is important that you, a family member or a friend call your Hamaspik CHOICE, Inc. care manager or call Hamaspik CHOICE, Inc. at the main number 1-855-55-CHOICE as soon as possible to rearrange any scheduled services you might miss at this time and begin making any necessary changes to your PCSP. We will help you avoid any unnecessary gaps in the services you need. If you are admitted to the hospital, you must inform us as soon as possible, so that we can arrange for resumption of your services and authorize any new services that may be required upon discharge.

Getting Help During Non-Business Hours

We always encourage you to call your Care Manager for any assistance - your Care Manager knows you and your needs best. However, if you have any urgent questions or need for assistance after hours or on weekends or holidays, just call us at the 24-hour toll-free number 855-552-4643 and an on-call representative will help you.

Services Outside the Service Area

If you have any changes in your health status while you are outside of our service area, you should call your Care Manager or Hamaspik CHOICE, Inc.'s general number and ask to speak with a nurse. The nurse will assist you in coordinating the services you need.

Any time you plan to be away from the area, you should notify your Care Manager so that we can help you arrange for services that are medically necessary while you are away from the area and we can suspend your regularly scheduled service until you return, and be sure that the services are available upon your return when you need them. You may not be absent from the service area for more than 30 consecutive days and remain enrolled in Hamaspik CHOICE, Inc. We are required to start the involuntarily disenrollment process when you are absent for more than 30 consecutive days (see section on Termination of Coverage).

Selecting Providers

For covered services, Hamaspik CHOICE, Inc. has a network of providers who provide high quality care and are committed to the Hamaspik CHOICE, Inc. mission of helping you to be as independent as possible. A list of Hamaspik CHOICE, Inc. providers is given to you upon initial assessment and is mailed annually. The Hamaspik CHOICE, Inc. Provider Directory is posted on the Hamaspik Choice, Inc. website, www.hamaspikchoice.org. The Provider Directory is updated with all new providers on a monthly basis. Additionally, an updated Provider Directory can be mailed to you, upon your request to your care manager. If there are other providers that you would like to have us include in our network, let us know and we will explore this option. If a network provider you are using is no longer going to be in the network, we will let you know immediately and will assist you in choosing another provider from our network. If you are in the middle of a course of treatment, you may continue with the provider for a period of up to 90 days. If you are a new member, you may continue an ongoing course of treatment with an out-of-network provider for an interim period of up to 60 days. In either case, Hamaspik CHOICE, Inc. permission is required and is dependent upon the provider's willingness to accept payment from Hamaspik CHOICE, Inc. and to comply with our policies and procedures.

- If Hamaspik CHOICE, Inc. does not have a provider in its network with the training and expertise to meet a specialized health care need included in your PCSP, we will approve services from a provider outside of our network.
- If you wish to change providers, call your care manager, who will help you identify another provider in our network. We want you to be satisfied with the services you receive.
- Each year, we will ask your opinion about the services you receive from our network providers and we will provide confidential feedback to providers to improve services.
- You have the freedom to choose providers for covered services paid for by Medicare. However, when Medicare stops paying for these services, you must use a network provider in order for Hamaspik CHOICE, Inc. to cover the service.
- Services not covered by Hamaspik CHOICE, Inc. will continue to be covered by Medicare and/or Medicaid fee-for-service. It is important to carry with you your plan benefit card, Medicare and Medicaid cards.
- Services that are not covered by Hamaspik CHOICE, Inc. do not need prior approval from Hamaspik CHOICE, Inc. Your care manager can coordinate these non-covered services for you. You may select providers of your choice for non-covered services and these providers

are paid by Medicare, fee-for-service Medicaid or third party insurance, if applicable. Services that are not covered include:

- Inpatient and outpatient hospital services
- Physician services
- Laboratory services
- Prescription, non-prescription and compounded prescription drugs
- Radiology and radioisotope Services
- Emergency transportation
- Rural health clinic services
- Chronic renal dialysis
- Mental health services
- Office for People with Developmental Disabilities (OPWDD) services
- Alcohol and substance abuse services
- Family planning services
- Hospice Services*

*members who are enrolled in Hamaspik Choice and subsequently elect hospice as a result of a qualifying condition, may continue to be enrolled in Hamaspik Choice. Hamaspik Choice will assure the proper coordination of care for members who elect to receive Hospice benefits, pursuant to NY PHL 4403-f. Hamaspik choice will also reevaluate your person centered service plan in consultation with the hospice and your physician to coordinate services and avoid duplication or conflict.

Person Centered Service Plan (PCSP)

Person centered service planning and care management entails the establishment and implementation of a written care plan and assisting you to access services authorized under the care plan. Person centered service planning includes consideration of your current and unique psychosocial and medical needs and history, as well as your functional level and support systems. Care management means a process that assists you with accessing necessary covered services as identified in the Person Centered Service Plan (PCSP). Care management services include referral, assistance in or coordination of services for you 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 Benefit Package.

Care Management

Hamaspik CHOICE, Inc.'s care management system ensures that care provided is adequate to meet your needs and is appropriately coordinated, and consists of both automated information systems and operational policies and procedures

that meet the requirements of 42 CFR 438.208, and are approved by the Department of Health.

Hamaspik CHOICE, Inc.'s care management system:

- a. Provides you with a minimum of one care management telephone contact per month
- b. Provides you with a minimum of one care management home visit every six (6) months
- c. Ensures that the level and degree of care management, and your Person Centered Service Plan (PCSP) address your needs and are based upon the acuity and severity of your physical and mental conditions;
- d. Is based on a ratio of care managers to enrollees taking into consideration a hierarchical structure based on the acuity and severity of your physical and mental conditions.
- e. Educates you, as applicable, about Consumer Directed Personal Assistance Services
- f. Educates you on service options when creating the Plan of Care with you after the initial assessment and reassessment visits;
- g. Has a maximum two business day response time to enrollee/member contacts.
- h. Has Care Managers who demonstrate appropriate backgrounds and have relevant degrees as necessary to meet your needs.

If

Service Authorizations

Your PCSP is the basis for our authorization or agreement to pay for a covered service. If you would like to receive a new, covered service not included in your current PCSP, or would like to change the amount, frequency or duration of a covered service you are currently receiving, prior approval is required.

A prior authorization is required when you request either a new service or a change in service for a new authorization period.

A concurrent review is required when you request more of the same service than is currently authorized by your PCSP. Either request may be considered by a standard or expedited review.

You may request an expedited review. However, the determination about whether the review will be expedited depends on whether Hamaspik CHOICE, Inc. or your provider determines that a delay would seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function. If you want to make such a request, you should contact your Care Manager.

For prior authorizations, expedited reviews are handled within 3 business days of your request.

Standard reviews are handled within 3 business days of receipt of necessary information, but no more than 14 days from when we receive your request.

For Concurrent Reviews, expedited reviews are handled within 1 business day of our receipt of necessary information, but no more than 3 business days after we received your request. Standard reviews are handled within 3 business days after receipt of necessary information, but no more than 14 days after receipt of request.

In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the request for services falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the request for services.

The review periods can be increased up to 14 days if you or your provider requests it or if we need more information and the delay is in your interest. If you are not satisfied with the decision we make, you can appeal it. Please see the section on Appeals on page ____ below.

Termination of Coverage

Your coverage under Hamaspik CHOICE, Inc. will stop if you choose to voluntarily disenroll or if you are involuntarily disenrolled. Until your disenrollment is effective, you will remain a member of Hamaspik CHOICE, Inc. This means that you must continue to follow your agreed-upon PCSP, continue to obtain prior approval for covered services, and continue to use network providers for covered services. Hamaspik CHOICE, Inc. will continue to cover services in your PCSP until the disenrollment is effective and will assist you in transitioning to other care arrangements. You may not be disenrolled because you have had an adverse change in your health or due to the cost of providing services.

If you decide you would like to disenroll from Hamaspik CHOICE, Inc., you may begin the process at any time by telling us in writing or verbally. You should discuss your wish with your care manager. You will be asked to sign a Disenrollment Form that will indicate the date upon which you are no longer entitled to receive services through Hamaspik CHOICE, Inc. If New York Medicaid Choice/LDSS processes your request by the twentieth of the month, the effective date of your disenrollment will be as of the first day of the following month. If it is later than the twentieth of the month, the effective date of disenrollment will be as of the first day of the second month following your disenrollment request.

If, after enrolling in Hamaspik CHOICE, Inc., you enroll in or receive services from another Medicaid prepayment plan, a HCBS waiver program, or an OPWDD Day Treatment Care Management program, the disenrollment will be considered voluntary disenrollment.

If you decide to disenroll from Hamaspik CHOICE, Inc. and you continue to require long term care services, such as personal care, you will be required to transfer to another MLTC plan, managed care plan or an alternate service plan in order to continue to receive these services.

Involuntary Disenrollment (Mandatory)

Hamaspik CHOICE, Inc. must initiate involuntary disenrollment within five business days from the date we know of that *any* of the following situations applies to you:

- You no longer live in the service area;
- You are absent from the service area for more than 30 consecutive days;
- You are hospitalized or enter an OMH, OPWDD, or OASAS residential program for 45 consecutive days or longer;

- You clinically require nursing home care but are not eligible for nursing home care under Medicaid Institutional rules;
- You are no longer eligible to receive Medicaid benefits;
- An enrollee whose sole service is identified as Social Day Care must be assessed and recommended for disenrollment from the MLTC plan within five business days of the assessment making such determination;
- You are assessed as no longer demonstrating a functional or clinical need for community based long term care services or, for non-dual eligible members, in addition no longer meet the nursing home level of care as determined using the assessment tool prescribed by the Department of Health; or
- You are incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration.

Involuntary Disenrollment (At Hamaspik CHOICE, Inc.'s Option)

Hamaspik CHOICE, Inc. may disenroll you if any of the following applies:

- You, your family or others in your immediate environment engage in behavior that jeopardizes your health or safety or the safety of others;
- You fail to pay or fail to make satisfactory arrangements to pay the spend-down/surplus amount due to Hamaspik CHOICE, Inc. after a thirty-day grace period;
- You knowingly fail to complete and submit any necessary consent or release; or
- You provide Hamaspik CHOICE, Inc. with false information, otherwise deceive us, or engage in fraudulent conduct in relation to your Hamaspik CHOICE, Inc. membership.

Any involuntary disenrollment requires approval of LDSS or New York Medicaid Choice. If approved, LDSS or New York Medicaid Choice will notify you in writing of the effective date of your disenrollment and your fair hearing rights.

Medicaid Spend-Down

The spend down amount you are required to pay to Hamaspik CHOICE, Inc. depends on the determination made by Medicaid. When LDSS reviews your financial status for purposes of determining your Medicaid eligibility it may determine that you must "spend-down" a portion of your monthly income in order to meet the income requirements for eligibility for Medicaid. If Medicaid determines that you must "spend-down" a certain amount, you must pay this amount to Hamaspik CHOICE, Inc. each month. LDSS will inform you and us of the exact amount of your "spend-down" that must be paid each month to us.

If Medicaid determines that you have no spend-down obligation, then you do not pay Hamaspik CHOICE, Inc. anything each month.

The amount you must "spend-down" or pay directly to Hamaspik CHOICE, Inc. may change with your periodic Medicaid eligibility certification process or admission into a Nursing Facility.

If you have a spend down, that amount must be paid by the first of each month starting with the month of enrollment. Please make your payment payable to the order of Hamaspik CHOICE, Inc. and send it to 58 Route 59, Suite 1, Monsey, NY 10952.

If you have a problem meeting this responsibility, it is important that you discuss the situation with our designated spend-down representative. If you do not pay your spend-down amount within 30 days after the date it is due, we will notify you in writing of your arrears in payment. We have the right to involuntarily disenroll you from the program for failure to make spend-down payments due.

Veterans Protections

There are currently no accessible veteran's homes operating within the Hamaspik CHOICE, Inc. service area. If an applicable enrollee desires to receive care from a veteran's home, Hamaspik CHOICE, Inc. will allow the enrollee to access the veteran's home services and will pay out of network until the enrollee has transferred to an MLTC Plan with an in-network veteran's home.

Rights and Responsibilities

As a member of Hamaspik CHOICE, Inc., you have the right to:

- Receive medically necessary care;
- Timely access to care and services;
- Privacy about your medical record and when you get treatment;
- Get information on available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand - you can receive verbal translation services free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Obtain a copy of your medical records and ask that the records be amended or corrected;
- Take part in decisions about your health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Receive care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the services you need from us, including how you can get covered benefits from out-of-network providers if they are not available in our network;
- Complain to the New York State Department of Health or your Local Department of Social Services and the right to use the New York State Fair Hearing System and/or New York State External Appeal, where appropriate
- Hamaspik CHOICE, Inc. may not act in any manner so as to restrict the Enrollee's right to a fair hearing or influence an Enrollee's decision to pursue a fair hearing.

- Appoint someone to speak for you on your behalf about your care and treatment; and
- Hamaspik CHOICE, Inc.
- Make Advance Directives and plans regarding your care. Please see page 51 of this document for details on Advance Directives.
- You have the right to seek assistance from the Participant Ombudsman program.

Your exercise of these rights will not adversely affect the way you will be treated.

As a member of Hamaspik CHOICE, Inc., you have the responsibility to:

- Receive covered services through Hamaspik CHOICE, Inc.;
- Use the Hamaspik CHOICE, Inc. network providers for covered services;
- Obtain prior authorization for covered services, except for pre-approved services. Refer to specific service in the Service Benefit Package section of this handbook to find out if a specific service requires prior approval;
- Be seen by your physician if a change in your health status occurs;
- Share complete and accurate health information with your health care providers;
- Inform Hamaspik CHOICE, Inc. staff of any change in your health and make it known if you do not understand or are unable to follow instructions;
- Follow your PCSP recommended by Hamaspik CHOICE, Inc. staff;
- Cooperate with and be respectful to Hamaspik CHOICE, Inc. staff and not discriminate against Hamaspik CHOICE, Inc. staff on the basis of race, color, national origin, mental or physical ability (other than mandated physical eligibility for the program), religion, age, sex, sexual orientation or marital status;
- Notify Hamaspik CHOICE, Inc. within 2 business days before receiving either non-covered services or pre-approved covered services.

We prefer that you notify us before receipt of services, but no later than 2 days after receipt.

- Notify Hamaspik CHOICE, Inc. in advance whenever you will not be home to receive service or care that has been arranged for you;
- Inform Hamaspik CHOICE, Inc. before permanently moving out of the service area or of any lengthy absence from the service area and also of any absence from the service area;
- Take responsibility for your actions if you refuse treatment or do not follow Hamaspik CHOICE, Inc. instructions; and
- Pay your financial obligations, if any.

Member Grievance and Appeal Process

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

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

To file a complaint or to appeal a plan action, please call: 855-552-4642 or write to: 58 Route 59 Suite 1, Monsey, NY 10952. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal. All complaint appeals will be conducted by appropriate professionals, including health care professionals for complaints involving clinical matters, who were not involved in the initial decision.

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

What is an Action?

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

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

Any notice we send to you about an action will:

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

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to

have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 855-552-4642 or writing to 58 Route 59 Suite 1, Monsey, NY 10952. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while your appeal is being decided. We must continue your service if you make your request no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later.

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our

decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

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

How Long Will it Take the Plan to Decide My Appeal of an Action?

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

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

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

Expedited Appeal Process

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

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

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

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

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

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

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 120 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the restriction, reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you will continue to receive these services while you are waiting for the Fair Hearing decision. Your request for a Fair Hearing must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires but no later than 72 hours from the date the plan receives the Fair Hearing decision. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: <http://otda.ny.gov/oah/FHReq.asp>
- Mail a Printable Request Form:

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

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

Standard Fair Hearing line – 1 (800) 342-3334
Emergency Fair Hearing line – 1 (800) 205-0110
TTY line – 711 (request that the operator call 1 (877) 502-6155)

- Request in Person:

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

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

State External Appeals

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

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

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

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

SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

Prior Authorization Review: review of a request by the Enrollee, or provider on Enrollee's behalf, for coverage of a new service (whether for a new authorization period or within an existing authorization period) or a request to change a service as determined in the plan of care for a new authorization period, before such service is provided to the Enrollee.

Concurrent Review: review of a request by an Enrollee, or provider on Enrollee's behalf, for additional services (i.e., more of the same) that are currently authorized in the plan of care or for Medicaid covered home health care services following an inpatient admission.

Expedited Review: An Enrollee must receive an expedited review of his or her Service Authorization Request when the plan determines or a provider indicates that a delay would seriously jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. The Enrollee may request an expedited review of a Prior Authorization or Concurrent Review. Appeals of actions resulting from a Concurrent Review must be handled as expedited.

General Provisions

Any Action taken by the Contractor regarding medical necessity or experimental or investigational services must be made by a clinical peer reviewer as defined by PHL §4900(2)(a).

Adverse Determinations, other than those regarding medical necessity or experimental or investigational services, must be made by a licensed, certified, or registered health care professional when such determination is based on an assessment of the Enrollee's health status or of the appropriateness of the level, quantity or delivery method of care. This requirement applies to determinations denying claims because the services in question are not a covered benefit when coverage is dependent on an assessment of the Enrollee's health status, and to Service Authorization Requests including but not limited to: services included in the Benefit Package, referrals, and out-of-network services.

The plan must notify members of the availability of assistance (for language, hearing, speech issues) if member wants to file appeal and how to access that assistance.

The Contractor shall utilize the Department's model MLTC Initial Adverse Determination and 4687 MLTC Action Taken notices.

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the Contractor must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:
 - a. Expedited: Seventy-two (72) hours of receipt of the Service Authorization Request
 - b. Standard: Fourteen (14) days of receipt of the Service Authorization Request
 - c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization Request.

3. Up to 14 calendar day extension. Extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.
 - a. The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and help the enrollee by listing potential sources of the requested information.

4. Enrollee or provider may appeal decision – see Appeal Procedures.

5. If the plan denied the Enrollee's request for an expedited review, the plan will handle as standard review.

- a. The Contractor must notice the Enrollee if his or her request for expedited review is denied, and that Enrollee's service request will be reviewed in the standard timeframe.

Other Timeframes for Action Notices

1. When the Contractor intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:
 - a. the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or
 - b. the Contractor may mail notice not later than date of the Action for the following:
 - i. the death of the Enrollee;
 - ii. a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
 - iii. the Enrollee's admission to an institution where the Enrollee is ineligible for further services;
 - iv. the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
 - v. the Enrollee has been accepted for Medicaid services by another jurisdiction; or
 - vi. the Enrollee's physician prescribes a change in the level of medical care.
 - c. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a)-(b).
 - i. For CBLTCS and ILTSS, when the Contractor intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level

or amount than previously authorized, the Contractor will not set the effective date of the Action to fall on a non-business day, unless the Contractor provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint Appeals and Action Appeals

- d. The Contractor must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,
- e. When the Contractor does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the Contractor must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

- 1. The Contractor must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program.
- 2. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:
 - a. the date the restriction will begin;
 - b. the effect and scope of the restriction;
 - c. the reason for the restriction;
 - d. the recipient's right to an appeal;
 - e. instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
 - f. the right of Contractor to designate a primary provider for recipient;
 - g. the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the Contractor affords the recipient a limited choice of primary providers;
 - h. the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
 - i. the right to a conference with Contractor to discuss the reason for and effect of the intended restriction;

- j. the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
- k. the name and telephone number of the person to contact to arrange a conference;
- l. the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
- m. the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
- n. the right of the recipient to examine his/her case record; and
- o. the right of the recipient to examine records maintained by the Contractor which can identify MA services paid for on behalf of the recipient. This information is generally referred to as "claim detail" or "recipient profile" information.

Participant Ombudsman Program

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

- providing pre-enrollment support, such as unbiased health plan choice counseling and general program-related information,
- compiling enrollee complaints and concerns about enrollment, access to services, and other related matters,
- helping enrollees understand the fair hearing, grievance and appeal rights and processes within the health plan and at the State level, and assisting them through the process if needed/requested, including making requests of plans and providers for records, and
- Informing plans and providers about community-based resources and supports that can be linked with covered plan benefits.
- You can reach the Participant Ombudsman Program (ICAN) at:

ICAN's Phone: 1-844-614-8800 TTY Relay Service: 711

Web: www.icannys.org | Email: ican@cssny.org

You may file a complaint with the NYS Department of Health at 1-866-712-7197

Money Follows the Person (MFP)/Open Doors

This section will explain the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

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

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

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

For more information about MFP/Open Doors, or for assistance to set up a visit from a Transition Specialist or Peer, please contact your Hamaspik CHOICE, Inc. Care Manager at 855-552-4642. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Additional Information Available Upon Request

If you request it, you may receive the following information:

- A list of the names, business addresses and official positions of the members of the Board of Directors and officers of Hamaspik CHOICE, Inc.
- A copy of Hamaspik CHOICE, Inc.'s most recent annual certified financial statements.
- A copy of Hamaspik CHOICE, Inc.'s written procedures for protecting the confidentiality of medical records and other member information.
- A copy of Hamaspik CHOICE, Inc.'s written procedures for making decision about the experimental or investigational nature of medical devices or treatments in clinical trials.
- A copy of Hamaspik CHOICE, Inc.'s written procedures for making service authorization decisions.
 - A copy of Hamaspik CHOICE, Inc.'s written application procedures and the minimum qualifications for health care providers to be considered for becoming participating providers within our network.
- A written description of our organizational arrangements and ongoing procedures for the quality assurance program.

Certain Definitions

Covered Services: Those medical and health-related services that are listed on pages 4 - 6 in the section entitled "Service Benefit Package" which members are entitled to receive.

Hamaspik CHOICE, Inc.: Hamaspik CHOICE, Inc. is a Managed Long Term Care Plan authorized to operate in New York State by the New York State Department of Health. Hamaspik CHOICE, Inc. is the entity bearing financial risk and legal responsibility under contract with New York State and enrollment agreements with its members. Related parties provide some services to Hamaspik CHOICE, Inc. members, including skilled nursing, long term care and day health services.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of

immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any of bodily organ or part of such person; or (d) serious disfigurement of such person.

Fee-for-service Medicaid: The traditional provider reimbursement in which the provider is paid according to the service performed.

Involuntary Disenrollment: When, in certain specific circumstances, your membership in Hamaspik CHOICE, Inc. may be cancelled, even if you are not choosing to disenroll.

Local Department of Social Services ("LDSS"): The local agency that must concur with the determinations made by a Managed Long Term Care Plan before an individual may be enrolled or denied enrollment into the program, or involuntarily disenrolled from the program. This agency also determines the monthly income spend-down due by the member, if any.

Managed Long Term Care Plans ("MLTC"): Programs designed for people who are chronically ill or disabled and need medical services at a nursing home level of care or require community-based long term care services for more than 120 days. Programs must be approved by New York State to operate, and receive a pre-determined rate of payment from Medicaid to provide medically necessary covered services to its members. MLTC programs bear financial risk and legal responsibility under contract with New York State and enrollment agreements with its members.

Medically Necessary. A service is considered medically necessary if it is needed to prevent, diagnose, correct or cure conditions in an individual that cause acute suffering, endanger life, result in illness or infirmity, interfere with the individual's capacity for normal activity or threaten some significant handicap.

Network Providers: Service providers carefully chosen by Hamaspik CHOICE, Inc. and contracted with to provide Covered Services to Hamaspik CHOICE, Inc. members.

Person Centered Service Plan (PCSP): A written description of the services, including frequency, that have been determined to be medically necessary as well as non-covered services you may be receiving.

Physician's Order: A written document signed by your physician authorizing medically necessary services.

Prior Approval: Except for certain pre-approved Covered Services, all Covered Services require Hamaspik CHOICE, Inc.'s advance or prior approval. Your care

manager will review your health care needs and confer with your physician to determine those medically necessary and authorized Covered Service in your PCSP.

Spend-down: The amount determined by Medicaid, if any, that you must pay to Hamaspik CHOICE, Inc. each month in order to qualify for Medicaid benefits and be eligible for the Hamaspik CHOICE, Inc. program if your monthly income exceeds the allowable maximum.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Uses and Disclosures

We typically use or share your health information in the following ways:

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

We can use and disclose your information to run our organization and contact you when necessary.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. You may request this by describing the information you want to review and the format in which you want to receive it in writing to Hamaspik CHOICE, Inc. 58 Route 59, Suite 1, Monsey, NY 10952.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may refuse your request in certain limited instances. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your privacy rights by contacting the Hamaspik CHOICE, Inc. Compliance Officer by phone at 845 503 0592 or by email at corporatecompliance@hamaspikchoice.org.
- You can 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 www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes

- Sale of your information

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- 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.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Additional Information

If you have any questions or would like additional information about this notice, please contact the Hamaspik CHOICE, Inc. Compliance Officer by phone at 845 503 0592 or by email at corporatecompliance@hamaspikchoice.org

Effective Date

- This Notice of Privacy Practices is effective as of July 21, 2014.

Advance Directives

Advance Directives are written instructions regarding your health care. Advance directives are developed by adults before the decision making capability is lost. Advance directives allow you to make your choices known, and to appoint someone you trust to carry out your choices, or make decisions if you are unable to do so. They ensure that your requests are fulfilled in the event you cannot make decisions for yourself.

These documents can provide instructions on what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf. It is your right to establish advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury.

It is the policy of Hamaspik Choice to support your right to participate in health care decision making. Hamaspik Choice encourages you, your family members, and your health care practitioners to discuss values and preferences that should guide your health care decision making if you are unable to do so yourself. For the purpose of this policy and procedure, advance directives will include:

- Health Care Proxy
- Non-hospital Order Not to Resuscitate (DNR Order)
- Living Will
- Medical Order for Life-Sustaining Treatment (MOLST).

Hamaspik Choice respects your right to choose and, in order to assure implementation of the policy to protect those rights, will provide the necessary documents and guidance to allow you to develop an appropriate plan.

As part of the enrollment process and before any care is rendered to you, the enrolling nurse will provide you with the following documents:

- Deciding About Health Care – A Guide for Patients and Families
- Appointing Your Health Care Agent – New York State’s Proxy Law
- Health Care Proxy form
- Medical Orders for life Sustaining Treatment form
- Hamaspik Choice will provide you with education regarding Advance Directives. Education will be provided upon initial assessment, upon re-assessment, and upon monthly phone contact.
- You will be educated on the benefits of executing advance directives.
- You will be notified of your rights in regards to advance directives
- You will be provided with documents to assist in this process.
- When setting up initial assessment visit and re-assessment visit, Hamaspik Choice will encourage you to have family present as it is beneficial to have family included in the discussion regarding Advance Directives.
- Health Care Proxy educational forms and MOLST forms will be distributed during the initial assessment visit.
- Upon re-assessment, the Nurse Assessor will re-educate and review your health Care Proxy educational forms and MOLST forms.
- You will be asked if you have executed an advance directive. The response will be noted in your member record. If you have advanced directives, you will be asked to provide a copy. The copy will be filed in your record.

- If you notify us that you have on file with your physician, your care manager will reach out to your physician to obtain a copy of these forms to have on file with Hamaspik Choice.
- Care Manager will coordinate with the physician that this be discussed at members next scheduled MD visit.
- If you express interest in advance directives at either initial or reassessment visit, your Care Manager will provide you with additional follow up on the forms with either a phone call or in home visit as requested. Follow up will include discussion with you and your family on importance of forms, and coordination with MD for forms completion.
- Hamaspik Choice will document and keep track of which members have been educated on Advance Directives, have expressed interest in Advance Directives, and have provided a copy of their Advance Directives. The reported information will afford Hamaspik Choice with ability to continue educating and providing guidance to its membership on the subject of advance directives.
- Hamaspik Choice may provide copies of the advance directive on file to designated health care professionals, upon your request.