



MEMBER HANDBOOK

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toll-free 1-866-843-7526
TTY NY Relay Dial 7-1-1

Elderwood Health Plan

A managed long term care plan

MEMBER HANDBOOK

For your convenience, we are providing you with this Member Handbook. Please keep this handbook as a reference, as it includes important information regarding Elderwood Health Plan and the benefits and options of our program. Please note that a copy of this Member Handbook is available in other prevalent languages upon request. You may also ask us for a large print or audio copy of this handbook should you need it.

This is important information about your health care benefits. Call Member Services at 1-866-843-7526, or if hearing impaired/TTY call NY Relay by dialing 7-1-1, for a translated version of this information. (For those with hearing impairment, NY Relay can connect you to anyone, anywhere, 24 hours a day, 7 days a week.)

Información importante sobre sus beneficios de atención médica. Llame a Servicios al Cliente, al 1-866-843-7526 si tiene dificultades de audición/TTY, llame al servicio Relay de NY al 7-1-1 para obtener una versión traducida de esta información.

这是关于您的医疗保付的重要信息。请拨打1-866-843-7526 致电会员服务中心，听力障碍人士或使用 TTY（文本电话）时，请拨打 7-1-1 致电 NY Relay，获得此信息的翻译版本。针对听力障碍人士，NY Relay 可以随时随地与您联系，提供一周七天的全天候服。

Это важная информация о покрываемых нами видах медицинской помощи («бенефитах»). Для получения перевода этой информации на ваш язык позвоните в Отдел помощи нашим клиентам по телефону 1-866-843-7526. Если вы слабослышащий, воспользуйтесь телефоном с текстовым выходом (TTY) через коммутаторную линию Нью-Йорка 7-1-1. Коммутаторная линия Нью-Йорка позволяет лицам с нарушениями слуха связаться с кем угодно, где угодно в любое время суток 7 дней в неделю.

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Important Phone Numbers

Member Service	1-866-THE-PLAN (1-866-843-7526)
Care Manager - 24 hrs/day, 7 days/week	1-866-843-7526
Elderwood Health Plan Fax number	716-568-8378
Language Assistance	1-866-843-7526
Hearing and Speech Disability Assistance	NY Relay 711
Report Fraudulent Billing Practice	1-855-663-0144 or NYS 1-800-663-6114
NYS Adult Protection Services (to report abuse)	1-844-697-3505
NYS MLTC Complaints	1-866-712-7197
NYS Fair Hearing	1-800-342-3334
Healthplex Member Services	1-800-468-9868

WELCOME TO ELDERWOOD HEALTH PLAN

Thank you for choosing Elderwood Health Plan as your managed long-term care plan. We look forward to being your health care partner. Elderwood Health Plan is committed to helping our members continue to live independently in their homes and communities for as long as possible. We promote choice in long term health care by directly involving you in planning your care and by offering a wide range of flexible services and schedules to fit your everyday needs. This managed long term care program provides innovative long term care solutions that are beneficial for each member.

What is Managed Long Term Care?

Elderwood Health Plan is a Managed Long Term Care Plan (MLTCP) for Medicaid recipients. The main goal of a managed long-term care plan is to help those individuals who are determined eligible for community-based long-term care services, for more than 120 days stay in their home and community for as long as possible. It provides the care and support needed to allow them to do the day-to-day activities that they may no longer be able to do without help. It provides needed medical, personal, and social services using a network of quality providers to select from. For example, an aide may be assigned to help with activities of daily living (dressing, bathing, meals) for those who can no longer do these things independently.

A Care Management Team is assigned to each member to meet individual needs. The team will help arrange care providers, services, and supports that are needed to remain independent as possible. However, at times you may need more care than we can give you at home. When this happens you may need to go to a nursing home. Your stay at the nursing home may be for a short time or it may be permanent. We are contracted with nursing homes to make sure that you have choices if you are no longer able stay safely at home. Your Care Manager will help you and your family with this decision.

MEMBER SERVICES: Just a Toll-Free Phone Call Away

1-866-THE-PLAN (1-866-843-7526)

Elderwood Health Plan Member Services assists you to understand your plan and receive the best possible care available. You may call Member Services to reach your Care Manager, ask questions about your covered benefits, obtain information about services and/or appointment times, replace a lost ID card, or to arrange medical transportation.

If you have a concern about any aspect of your care coordinated by Elderwood Health Plan, Member Services is there to help. Member Services specialists are available by telephone to help you answer questions you may have and will work directly with your care team to arrange for authorized services.

Call Member Services with your questions or concerns by dialing **1-866-843-7526**. If hearing or speech impaired please call NY Relay by dialing 7-1-1. The Member Service hours of operation are Monday through Friday, 8 a.m. - 4 p.m. For urgent matters which cannot wait for Member Services, Care Management is available 24 hours a day, seven days a week.

These are some of questions Member Services can answer:

- What are your rights and responsibilities?
- How and where do you get care?
- What are your benefits and health care services?
- What is an advance directive?
- How do you get advance directive information?
- How do you file a complaint or grievance?
- How do you get a Fair Hearing?
- How do you get a ride to medical services?

Language, Formats, and Interpretive Services

Elderwood Health Plan is dedicated to ensuring that our members are part of the care planning process. Your Care Manager will ensure that, if you speak a language other than English, materials you receive are translated into the language you speak. Elderwood Health Plan offers written information in the most prevalent languages of our members.

You may obtain a copy of this handbook and other member information in a different language or format. You may request your Member Handbook in the following formats:

- Printed in another language
- Large print
- Recorded

All handbooks and member information in other formats or languages are free. Call Member Services toll free at **1-866-843-7526** to ask for a copy.

If your main language is not English, please call Member Services. We will get you an interpreter who can translate any language.

We will also help you if you need a sign language interpreter. Let us know 3 days in advance if you need a sign language interpreter. These services are free.

If you have a hearing or speech disability, you can also call NY Relay by dialing 7-1-1. The Operator will facilitate the calls between speech or hearing-impaired members and Member Services specialists.

Care Manager

One of the benefits of membership in Elderwood Health Plan is having a Care Manager assigned to you to help you direct your care. We understand how difficult it can be to arrange the services you need. We are here to help. Your Care Manager will assist you in obtaining services, planning your care, and answering any questions you may have regarding health care services you may need. You may contact your Care Manager by calling Member Services at 1-866-843-7526, Monday through Friday from 8:00 am - 4:00 pm. Your Care Manager and Member Services specialists will work with your health care providers to ensure that you receive the care that you need in a timely manner. You can use the same phone number to contact us after hours to be connected to a member of the Care Management Team. **In the event of a medical emergency, please dial 911 or proceed to the nearest hospital.**

Important Phone Numbers for Elderwood Health Plan

You can reach Elderwood Health Plan (24 hours per day, 7 days per week) by calling 1-866-843-7526, or for hearing and speech impaired, by dialing 7-1-1 to reach NY Relay.

Routine Member Service Calls are taken Monday through Friday, 8:00 am - 4:00 pm.

What to Do in a Medical Emergency

In the event of a medical emergency, please dial 911 or go directly to the nearest hospital emergency department. Be sure to bring any pertinent information including your insurance card and current medications or list of medications.

Website

Elderwood Health Plan also has an easy-to-use website. This website makes it easy for you to find a provider in your area and access benefit information. Go to www.ElderwoodHealthPlan.com.

ELIGIBILITY CRITERIA

In order to enroll in a managed long-term care plan, an applicant must meet eligibility criteria. An applicant is eligible to become a member of Elderwood Health Plan if he or she:

- Is at least 21 years of age or older
- Is a resident of Erie, Niagara, Genesee, Orleans, Wyoming or Monroe Counties
- Is eligible for Medicaid, as determined by the Local Department of Social Services or entity designated by the Department of Health (DOH)
- Is determined eligible for community-based long term care for more than 120 days, by Elderwood Health Plan or entity designated by the Department of Health, by a trained RN using an eligibility assessment tool designated by the DOH
- Is capable at the time of enrollment of remaining in or returning to his/her home and community without endangering his/her health and safety, based on New York State Department of Health criteria; or is permanent resident of a Nursing Home and has been determined eligible for long term Medicaid by the Local Department of Social Services or entity designated by the State
- Is expected to require at least one of the following community-based long term care services for more than 120 days from the effective enrollment date:
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Private duty nursing
 - Consumer Directed Personal Assistance Services (CDPAS)

You will only be enrolled into Elderwood Health Plan once it has been determined that you are eligible for community-based long term care for more than 120 days, a comprehensive assessment of your needs is completed, and you sign the enrollment agreement. Elderwood Health Plan's initial assessment for MLTC eligibility will be conducted within 30 days of the first contact to Elderwood Health Plan requesting enrollment.

Denial of Enrollment

Elderwood Health Plan may find an applicant not eligible to enroll in our plan because he/she does not meet the above criteria. If you do not meet the eligibility criteria, Elderwood Health Plan will recommend denial of your enrollment to the Local Department of Social Services (LDSS). Only the LDSS may deny your enrollment and will notify you of your enrollment denial rights.

Withdrawal of Enrollment

You may withdraw your application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating your wishes verbally or in writing. A written acknowledgment of your withdrawal will be sent to you.

If you are determined to be clinically ineligible for Elderwood Health Plan, you will be advised and you may withdraw your application. Clinical ineligibility means that, based on the assessment completed by the assessment nurse, an applicant does not require community-based long term care services for more than 120 days or cannot live at home without endangering his/her health and safety.

If you do choose not to withdraw your application, your application will be processed as a proposed denial and will await review by LDSS for and enrollment determination.

JOINING ELDERWOOD HEALTH PLAN

Elderwood is a managed long-term care plan. You have a choice of managed long-term care plans serving your area. If you change your mind about joining Elderwood, you can disenroll at any time.

Your enrollment in Elderwood Health Plan will not affect your Medicare or Medicaid benefits. You can keep your doctors and your physician visits, laboratory, pharmacy, and hospitalizations are still covered by Medicare or Medicaid. Your Care Manager will help you coordinate these services.

If you are a new member and are receiving ongoing homecare services, Elderwood Health Plan will continue to provide services authorized under your pre-existing service plan for a minimum of 90 days. If you are receiving services from a provider who is not in our network, you may continue the treatment for up to 90 days from the day you enroll with Elderwood if we are unable to utilize an in-network provider for the same level, scope, and amount of services you were receiving. We will try to continue your provider after the initial 90 days only if the provider agrees to:

Accept the Elderwood payment rate

- Adhere to Elderwood policies including quality assurance
- Provide medical information about your care to Elderwood

Elderwood does not discriminate or limit enrollment based on your health status, a change in your health status or the cost of services you need.

Enrollment in Elderwood Health Plan is always open. We're here to answer questions and provide guidance through every step of the registration process so care can continue in the comforts of home.

How Do I Enroll?

If you would like to enroll with Elderwood Health Plan, call us at 1-866-843-7526. We would love to have you as our member! We can discuss the services we offer and answer any questions you may have to determine if a MLTC is right for you. We will help schedule an assessment that will determine if you are eligible for a MLTC plan and help you apply for Medicaid benefits if needed.

During your initial conversation with our Member Services Representative, we will advise you to contact the Conflict Free Evaluation and Enrollment Center (CFEEC) to schedule an assessment with an RN to determine your MLTC eligibility. The CFEEC is run by Maximus/New York Medicaid choice, an enrollment broker contracted with the New York State Department of Health to perform uniform, unbiased assessments to determine eligibility. We will either warm transfer (three-way call) you to the CFEEC or provide the phone number for you to call at your convenience. To schedule an assessment with the Conflict Free Evaluation and Enrollment Center, please call 1-855-222-8350. All individuals who wish to join a managed long term care plan such as Elderwood Health Plan for the first time must contact the CFEEC to schedule an evaluation/assessment prior to being enrolled into the plan. Once the CFEEC has determined you eligible for MLTC services, they will put you in contact with your plan of choice.

If you are eligible for MLTC we hope you will **make Elderwood Health Plan your Plan of Choice.**

We will make becoming a member easy by coming to you to provide plan information and involve you and your family in planning the services you need.

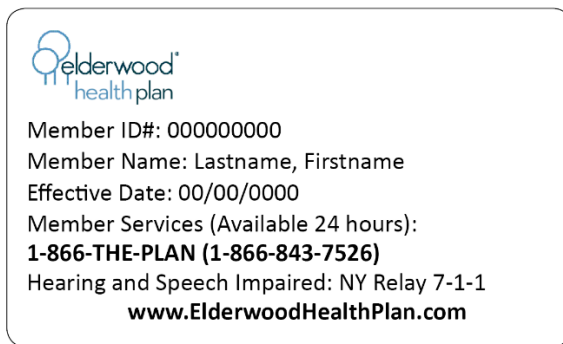
MEMBER IDENTIFICATION CARDS

Identification Cards

When you first join Elderwood Health Plan you will be given a temporary paper insurance Identification Card (ID card) to use while a plastic permanent ID card is being made. You will receive the permanent ID card in the mail. Your ID card has your effective date of coverage printed on it. This is the date that you can start receiving services as a member of Elderwood Health Plan. To make sure you get covered services, please do the following:

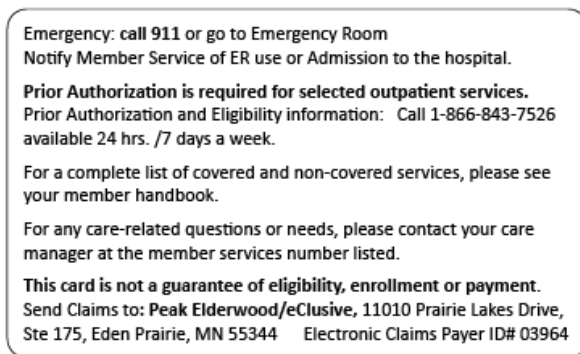
- When you receive your ID card, verify that all information is correct on your card. Call Member Services if there is a mistake on your card.
- If you do not receive your card, or if your card is lost or stolen, call Member Services to alert us of your issue. We will send you a new card.
- Never let anyone else use your ID card.
- Carry this card, your Medicare and/or Medicaid card, and any other third party insurance cards with you at all times. You will need them to receive medical and hospital care.

Front of EHP Member ID card:



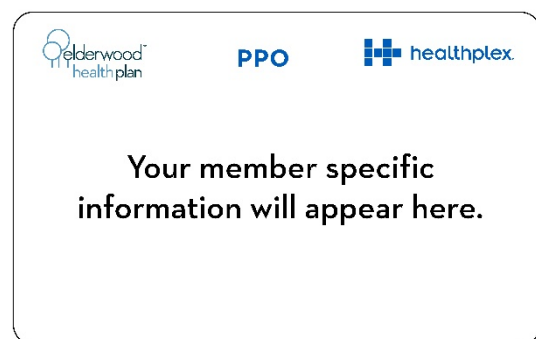
The front of the EHP Member ID card features the Elderwood Health Plan logo in the top left corner. Below the logo, the card displays the following information: Member ID#: 000000000, Member Name: Lastname, Firstname, Effective Date: 00/00/0000, Member Services (Available 24 hours): 1-866-THE-PLAN (1-866-843-7526), Hearing and Speech Impaired: NY Relay 7-1-1, and the website www.ElderwoodHealthPlan.com.

Back of EHP Member ID card:



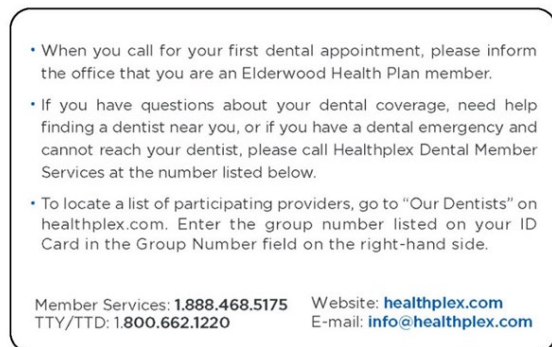
The back of the EHP Member ID card contains the following information: Emergency: call 911 or go to Emergency Room; Notify Member Service of ER use or Admission to the hospital; Prior Authorization is required for selected outpatient services; Prior Authorization and Eligibility information: Call 1-866-843-7526 available 24 hrs. /7 days a week; For a complete list of covered and non-covered services, please see your member handbook; For any care-related questions or needs, please contact your care manager at the member services number listed; This card is not a guarantee of eligibility, enrollment or payment; Send Claims to: Peak Elderwood/eClusive, 11010 Prairie Lakes Drive, Ste 175, Eden Prairie, MN 55344 Electronic Claims Payer ID# 03964.

Front of EHP/ Healthplex Dental Card (see page 22 for more information)



The front of the EHP/ Healthplex Dental Card features the Elderwood Health Plan logo in the top left corner, the PPO logo in the top center, and the Healthplex logo in the top right corner. Below the logos, the card displays the text: Your member specific information will appear here.

Back of EHP / Healthplex Dental Card



The back of the EHP / Healthplex Dental Card contains the following information: • When you call for your first dental appointment, please inform the office that you are an Elderwood Health Plan member. • If you have questions about your dental coverage, need help finding a dentist near you, or if you have a dental emergency and cannot reach your dentist, please call Healthplex Dental Member Services at the number listed below. • To locate a list of participating providers, go to "Our Dentists" on healthplex.com. Enter the group number listed on your ID Card in the Group Number field on the right-hand side. Member Services: 1.888.468.5175 Website: healthplex.com TTY/TTD: 1.800.662.1220 E-mail: info@healthplex.com

When Personal Information Changes

It is very important that we have your correct information. If there has been a change in your personal information and we have not been notified, you may not get important notices from us or we may not be able to help you with your health care. Please call Member Services toll free at **1-866-843-7526** if any of the following occur:

- You change your address or phone number. You must also call your local New York Department of Social Services to let them know about the change.
- You change your Primary Care Doctor or begin any new medical services or treatments we may not know about.
- There is a new contact person we can call in case we cannot get a hold of you.
- You get any other health insurance.

CARE MANAGEMENT

Care Management Team

Elderwood Health Plan provides every member with a Care Manager as part of a Care Management Team. The Care Manager leads the team. Your Care Manager is a health care professional, generally a nurse or a social worker. The Care Management Team includes a Registered Nurse, Social Worker, and a Member Service Representative to help with your daily needs. Your Care Management Team will work with you to make sure you get the health care and services you need. The Care Management Team can schedule medical appointments for you and arrange transportation, if needed, to health care services you need.

Person Centered Service Plan/Care Plan

Once you agree to become a member of Elderwood, your Care Manager will talk to the nurse who made your home visit. The information from your home visit will be reviewed. Your Care Manager will then contact you to talk with you more about your needs. Together you will develop your person-centered service plan (plan of care).

Your service plan is based on your health status and health care needs. Your Primary Care Physician may give us information, talk with you and your care manager, and help develop your service plan. It is important for you to contact us when you see a physician, as your Care Manager will make every effort to involve your physician in your service plan development and monitoring. Your Care Manager may consult with your physician on changes to your condition and medical needs. We will also get input from your family, caregivers, and others that you think are important for us to talk with regarding your care. The service plan will describe the personal care hours and other services you need.

Your service plan is important. It includes the services we will pay for, along with coordination of other necessary services not covered, to help you stay as healthy as you can be. You and your Care Management Team will review your condition changes to make sure you receive the services you need. Your Care Management Team will help to coordinate your care (such as physician visits, prescription drugs, and hospital admissions) with other health care providers.

Keep in Contact

Your Care Manager will call you at least once a month to check on you. They will also visit you at your home at least once every six (6) months. This is necessary to update your service plan to assure you have the appropriate services in place. You can call to talk to your Care Management Team at any time. If you need help after work hours or on weekends, your call will be sent to someone that can help you right away. Please call Member Services toll free at 1-866-843-7526. You can participate in your care by sharing with your Care Management Team your needs and concerns so that you may continue to live independently in your community.

Health Care Appointments

Tell your Care Management Team about your medical or health care appointments. You should also tell your Care Manager about what happened at your medical or health care appointment. Include information about any changes to your medications or services. If you are unsure about what happened, tell your Care Management Team. Your Care Manager will help you understand what happened. Your Care Manager will also help you include any new information in your service plan.

PAYMENTS AND BILLING

Medicaid Spend-down/Surplus Payments

Some members may have a monthly spend-down or surplus payment to be eligible for Medicaid services. If the spend-down applies to you, here are the rules:

- The spend-down amount is determined by the Local Department of Social Services and Elderwood is required to collect this payment from you.
- If the spend-down payments are not made, then you are not eligible for Medicaid.
- People not eligible for Medicaid cannot be enrolled in a managed long-term care plan such as Elderwood.
- Elderwood will send you a monthly bill for the amount you owe.
- Timely payments must be made directly to Elderwood on a monthly basis.
- If you fail to pay the amount owed within 30 days of receipt of the bill, we have the right to start your disenrollment (leaving the plan).
- If Elderwood does not receive a spend-down payment within three months of the date it is due, you will be disenrolled from the plan.
- Contact your Care Manager for help as soon as you have any issues with paying your monthly spend-down.

Spend-down payments can be in the form of check or money order (not cash), and should be sent to the following address:

Elderwood Health Plan
Attn: Billing Department
500 Seneca St., Suite 100
Buffalo, NY 14204

How Services are Paid

When you receive services authorized by Elderwood Health Plan, the health care provider will be paid directly by Elderwood. You are not responsible for paying for plan authorized medically necessary care. A provider may, by mistake, send you a bill for the services you received through Elderwood. If you receive a bill for services that were authorized by Elderwood, please contact us so we can help to ensure that all services are billed appropriately.

When a Member is Responsible to Pay for Service

It is important for you to contact your Care Manager to request authorization for services. If you receive out-of-network services that are not authorized you may be responsible for paying the bill.

Other Insurance

It is important to contact Member Services at 1-866-843-7526 if you have any changes with other health insurance. Elderwood will work with other health insurance plans to coordinate payment for services that are covered by both plans. If you get a bill for services covered by Elderwood Health Plan, for an amount another insurance company did not pay, contact Member Services so we can help to ensure that all services are billed appropriately.

CHOOSING A PROVIDER

Use the Elderwood Providers of Service (In-network)

Unless otherwise approved by the care management staff ahead of time, Elderwood members must use in-network, contracted providers, to obtain covered long term care services. If we do not have the type of provider you need, your Care Management Team will find a provider that is out-of-network. If you need a provider that is not in our network, you must call your care management team.

The **Provider Directory** identifies health care providers that participate in the Elderwood Health Plan and is available online at www.ElderwoodHealthPlan.com. A copy was also given to you during the home visit when you applied for Elderwood Health Plan.

The following information can be found in the Provider Directory:

- The in-network list of Elderwood Health Plan Providers and the service they provide
- The Providers' phone number and address
- Providers that speak languages other than English
- Providers that are accessible to people with disabilities
- Providers that can be seen without an authorization

You can call Member Services at 1-866-843-7526 if you need a new copy of the Provider Directory. You can choose from any network provider. If you wish to change providers, call your Care Management Team to help.

If you want help finding a provider for any health care services, call your Care Management Team or Member Services at 1-866-843-7526. They will be glad to help you. You may also call Member Services if you want a provider to be added to our network. If the provider meets our standards, we will ask them to join our network.

Transitional Care

If you are receiving services from a Medicaid community based long term care program, Elderwood Health Plan will continue to authorize and cover your community-based long term care services or institutional long term care services and supports for ninety (90) days following your enrollment, or until your person-centered service plan is in place, whichever is later.

A. If you are a new enrollee and you are currently receiving ongoing service that is covered by Elderwood Health Plan from a provider that is not in the Elderwood Provider Network, you may also continue to receive care from your current provider for a transitional period of up to ninety (90) days if Elderwood Health Plan is unable to utilize an in-network provider for the same level, scope, and amount of services you were receiving.

B. If your provider is leaving the Elderwood Health Plan network (cancels participation with our plan), you will receive written notification. If you are receiving services from this provider, it may be continued for a transitional period of up to ninety (90) days if Elderwood Health Plan is unable to utilize an in-network provider for the same level, scope, and amount of services you were receiving.

Transitional care may be provided as stated above (in A. and B.) if the non-network provider will:

- Accept payment from Elderwood at a negotiated rate
- Adhere to Elderwood quality assurance and other policies
- Provide medical information to your Care Manager about the care provided to you

Out of Network Care

A provider has to be participating (contracted with) Elderwood Health Plan to be an in-network provider. A health care provider can practice within our service area and not participate with the plan. Providers that do not participate with Elderwood are out-of-network providers.

In some circumstances, your Care Manager can authorize care to be provided to you by an out-of-network provider. You may obtain a referral to a health care provider outside the network in the event Elderwood does not have a provider with appropriate training or experience to meet your needs. If you require an out of network provider, please contact your Care Management Team to assist you in obtaining an authorization.

Payment will not be made for out-of-network providers not authorized in advance (Prior Authorization) by Elderwood, even if the health care provider practices within the service counties. Should you request to obtain care from a provider not in the Elderwood Health Plan network, your Care Manager will review the circumstances and if appropriate, provide authorization.

Please note: If you seek care from providers who do not participate in the Elderwood Health Plan network without a prior authorization, you will be financially responsible for payment of these services.

Out of Service Area Care

The Elderwood Health Plan service area is made up of Erie, Niagara, Orleans, Genesee, Wyoming and Monroe counties. If you are outside the Elderwood Service area, the health care providers will not be in our network. You must inform your Care Manager when you travel outside your covered service area so any services scheduled for you at home can be cancelled. Should you find yourself in need of services outside the Elderwood coverage area, contact your Care Manager to assist you in arranging care. If you are planning to spend time away from your home, please let your Care Manager know immediately. If you are out of the service area for 30 days or less, we will make every effort to assist you in arranging temporary services. If you are planning to leave the service area for more than 30 consecutive days, it will be difficult for Elderwood Health Plan to monitor your health needs and therefore, you will no longer be eligible for MLTC coverage. When you are no longer eligible for MLTC services, state rules require you to leave the plan (disenrollment). In this case, you should call your Care Manager to discuss your options.

Out of Service Area Emergency Care

Emergency Care is needed for sudden onset of a condition that poses a serious threat to your health or body function.

You do not need to call us or get prior authorization for out of area emergency care.

Emergency services are not covered by Elderwood but are covered by Medicare and Medicaid. Please call us if you use the emergency room or are hospitalized outside of the Elderwood service area. If you are hospitalized, a family member or other caregiver should contact us within 24 hours of admission. It is very important for us to know this so we can cancel your scheduled home care services. Please be sure to tell the hospital discharge planner to contact Elderwood Health Plan so that we may work with them to plan your services for discharge from the hospital.

MEMBER BENEFITS AND COVERED SERVICES

Medical Necessity

The services you receive, how often, and how long you get them is based on your medical condition, health, and social needs. You will receive covered services as long as they are medically necessary. A service is medically necessary if it is needed to prevent, diagnose, correct, or cure conditions that may cause suffering, endanger life, result in illness or hospital care, interfere with your ability for normal activity, or may cause a handicap.

The Service Plan that you develop with your care manager will help make sure that you get what you need. Sometimes we may need to review your request before you get the service. We may ask your Primary Care Physician for information. This is to make sure you get the right care at the right place when you need it.

The criteria we use to make our decisions are used by other health plans across the country and help us make the best decision we can about your care. You or your-physician can obtain a copy of the guidelines we use to approve or deny services. If you want a copy of the guidelines or do not agree with the denial of your services, please call your Care Manager or Member Services at 1-866-843-7526.

Services Covered by Elderwood Health Plan

Covered Services are services that we will pay for because you are a member of Elderwood Health Plan. Most services need to be authorized by Elderwood to be covered. When you require medically necessary services, as described below, we will authorize payment to network providers of these covered services. You are not liable (do not have to pay) for the costs of authorized covered services. The providers listed in the Provider Directory are paid directly by Elderwood for the covered services they provide to you. Your Care Manager will assist you in accessing the covered services that have been identified in your Service Plan. You will be able to access the care and services you need by calling your Care Management Team. The services you need will be put on your service plan.

If deemed medically necessary, the following are the kinds of services that Elderwood will pay for you to receive:

Adult Day Health Care

Adult Day Health Care is a service that may be used if you can leave your home, but need help doing some things by yourself. It is care that is provided in a residential health care facility or approved site to those individuals that are not homebound but require certain daytime services. The Adult Day Care staff can help you with your health care, nursing, meals, and social service needs. You may also get rehabilitation therapy and do many fun activities. Your Care Management Team will help you plan which services you get from the program. Adult Day Care has a nurse to help with taking medications and staff to help with dressing and using the bathroom. They give you lunch and provide any needed assistance. There are people to visit with and various activities in which you can participate.

Care Management

One of the most important benefits for all Elderwood members is having a personal Care Manager to assess your needs and coordinate your services. With Elderwood, you truly have a partner in care and our goal is to aid in your wellness. Your Care Manager is a registered nurse or a licensed social worker who will work with you to seek and coordinate solutions to meet your health and long term care needs. Your Care Manager will create an individual, person-centered service plan that will outline the services that are medically necessary for you to receive. Your Care Manager will authorize for you to start or continue receiving services, as well as make receiving these services as easy as possible. Your Care Manager will work with your physicians and other health care providers to coordinate both your covered and non-covered services.

Consumer Directed Personal Assistance Services

Consumer Directed Personal Assistance Services (CDPAS) provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Members have flexibility and freedom in choosing their caregivers. The member or the person acting on the member's behalf (member may designate a representative) assumes full responsibility for hiring, training, supervising, and terminating the employment of persons providing the services.

Dental Services

Dental services are very important to maintaining overall health and wellbeing. The dental care benefit is managed by Healthplex, which offers a robust network of dental providers to meet your needs. Dental providers specialize in the care and treatment of teeth and gums. Services include preventive, routine exams, oral surgery, and dental prosthetic (dentures) and orthotic appliances required to alleviate a serious health condition. Covered services from a Healthplex dentist listed in our Provider Directory include:

- One (1) exam each year
- One (1) cleaning every six (6) months
- X-rays
- Restorative dentistry (fillings)
- When medically necessary:
 - Oral surgery
 - Root canals (pre-authorization is required)
 - Crowns and Dentures (pre-authorization is required)

A referral from a Healthplex General Dentist is required prior to visiting a Healthplex dental specialist. To find a dentist in your area, call 1-800-468-9868 or TTY/TDD 1-800-662-1220 and tell them you are a member of Elderwood Health Plan. The Healthplex operator will give you a list of dentists near you to select from. For further assistance in arranging dental services you can contact your Care Manager and they will help you schedule an appointment. It is very important that you bring your Elderwood Health Plan Member ID card with you to your scheduled appointment so the dentist can bill us.

Dietary Counseling

Dietary counseling is nutritional counseling or teaching on healthy food choices. This can include the assessment of nutritional needs and/or the planning for appropriate meals and nutritional supplements to meet your needs.

Durable Medical Equipment (Medical Equipment for Home Care)

Durable Medical Equipment is equipment and devices that have been ordered by a practitioner in the treatment of a specific medical condition. Durable Medical Equipment can withstand repeated use for an extended period of time, is primarily and customarily used for medical purposes, and is generally not useful in the absence of an illness or injury. Some examples of Durable Medical Equipment include:

- Hospital bed
- Wheelchair
- Home oxygen
- Walkers and canes
- Commode
- Shower chair

Eye Exams, Eye Glasses and Optometry

Eye care services include visits to check your eyes and assess how well you see. It includes eyeglasses, medically necessary contact lenses, polycarbonate lenses, artificial eyes, and low vision aids. An optometrist is a specialist that is trained to diagnose and treat eye conditions. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member's condition. He or she is trained to prescribe and fit eyeglasses or lenses to improve your vision. Eye glasses are replaced every two (2) years (or more frequently if medically necessary).

Foot Care and Podiatry

A podiatrist is a specialist often referred to as a "foot doctor". They diagnose and treat conditions affecting the foot and ankle. Services provided may include routine foot care when it is medically necessary for the member, such as a serious foot condition or diabetic foot care. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet is not routinely covered, but may be covered if your Care Manager deems it necessary. For most members, podiatry care is covered by Medicare. An authorization is required if the services you need are not covered by Medicare. If you need to see a podiatrist, please discuss this with your Care Manager.

Hearing Tests/Hearing Aids/Audiology

Audiology services include testing, treatment, equipment to help you hear better, hearing aid evaluation, hearing aid prescription, or recommendations by an audiologist. Hearing aid services include the selecting, fitting, and dispensing of hearing aids, hearing aid checks following dispensing, and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings, and replacement parts. If you think

you need a hearing exam, we may ask you to see your doctor first, to be sure that another health problem is not affecting your ability to hear.

Home Delivered Meals/Congregate Meals

Home delivered meals are delivered to your home when you cannot cook and no one is available to prepare meals. The type of meal will be based on the service plan. Typically, one or two meals are provided per day for individuals who are unable to prepare meals and who do not have personal care services to assist with meal preparation. Congregate meals are nutritionally balanced meals served at a group setting in a specific location such as at an adult day care, community center, or senior center.

Home Health Aide (HHA)

A Home Health Aide is someone who helps you with health care tasks. The HHA provides services based on the service plan set by your Care Management Team, home health RN, or therapist. The HHA may also help you with tasks such as meal preparation, bathing, dressing, and using the bathroom.

Home Health Care

Home health care includes services such as nursing, home health aide, physical therapy, occupational therapy, speech therapy, and medical social services, which are of a preventive, rehabilitative, health guidance or supportive nature.

Home Health Nurse

Your physician may order Home Health Nursing services. The home health nurse will either be an RN or an LPN, based on your type of care needs. The amount of time the nurse is at your home is based on your health care needs. The nurse may visit occasionally when you have a special need. The nurse may also schedule regular times with you. Nursing services include setting up medicine, giving medicine, wound care, health care teaching, and other health care treatments.

Medical Supplies

Medical supplies are items used to treat a specific medical condition and are usually consumable, non-reusable, disposable and for a specific purpose. Examples are supplies to treat and/or manage diabetes, urinary incontinence, and ostomy care.

Medical Social Services

Medical social services include the checking, setting up, and providing help for social problems in order to keep you in your home. Services are performed by a qualified social worker and provided within a plan of care.

Nursing Home Care

A nursing home is a licensed facility with nursing aides and skilled nurses on hand 24 hours a day to provide health care and assist with personal care needs. When it is not feasible to continue long term care in the home, it is more appropriate for people to receive long term care in a nursing home. Admission to one of our participating nursing homes is made on an individual basis. The decision to receive care in a nursing home is made by the member, his/her physician, family and the Care Manager. Members with

current Medicaid eligibility covering community services only, may need to complete an application for institutional Medicaid to be submitted to the LDSS to determine Medicaid eligibility for nursing home care. The Elderwood social worker can help you apply to the LDSS for this. Elderwood does not cover long term nursing home care in an out-of-network nursing home. If a member chooses to stay in an out-of-network nursing home, he/she must be disenrolled from Elderwood Health Plan.

Elderwood Health Plan will contract with at least one veteran's nursing home, provided that one operates in our service area. We will notify each veteran member, spouse of a veteran member, or Gold Star parent member in need of long term placement about the availability, or lack thereof, of a veteran's home in our network. If Elderwood Health Plan is not contracted with a veteran's home and an applicable member desires to receive care from one, we will allow the member to access the veteran's home services out-of-network until he/she have transferred to another MLTC plan with an in-network veteran's home. The member will be referred to Maximus, or other NYS designated enrollment broker, for further assistance.

Nutrition Supplements

Nutrition supplements are usually limited to the case when a person cannot chew or swallow food and requires liquid food to be fed through a special feeding tube. Some members may have rare disorders that keep them from getting major nutrients unless they get specific nutrition supplements (medical food).

Occupational Therapy (OT)

Rehabilitation OT services are provided by a licensed and registered occupational therapist. The purpose of OT is to reduce any physical disability and provide treatment and exercises that will help you do your day to day activities more effectively after you have had a health problem or injury. These activities may include washing yourself, getting dressed, and combing your hair. It may also include helping you learn to write and feed yourself. You may be allowed up to 20 visits per year when provided in a setting other than a home (outpatient).

Personal Care

Personal care includes some or total assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care must be medically necessary, in accordance with the plan of care, ordered by the member's physician, and provided by a qualified person as determined by regulation.

Personal Emergency Response Systems (PERS)

A personal emergency response system is an electronic device that enables members to secure help in the event of an emergency (including a physical, emotional, or environmental emergency). Such systems are usually connected to a patient's phone and signal a response center when a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.

Physical Therapy (PT)

Physical therapy services are provided by a licensed and registered physical therapist. The purpose of PT is to reduce physical disability. The PT helps you move better and decrease any pain you may have. Physical therapy may include walking, heat packs, or exercises. You may be allowed up to 20 visits per year when provided in a setting other than a home (outpatient).

Private Duty Nursing Services

Private duty nursing is medically necessary services provided at a member's permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses, in accordance with physician orders. These services may be continuous and go beyond the scope of certified home health care agencies.

Prosthetics and Orthotics

Prosthetics are appliances and devices which replace any missing part of the body (for example, an artificial limb). Orthotic appliances and devices are used to support a weak or deformed joint, or to restrict or eliminate motion in a diseased or injured joint (for example, a brace).

Rehabilitation Therapies (Outpatient)

Rehabilitation therapies are services provided by licensed and registered therapists outside the home for the purpose of maximum reduction of physical disability and to restore your best functional level. Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy are limited to 20 visits per calendar year. These Medicaid limits apply to therapy visits that you receive in a setting other than a home. Additionally, these service limits do not apply if more services are authorized by your Care Manager.

Respiratory Therapy

Respiratory therapy is performed by a qualified respiratory therapist and consists of treatments to help you breathe better. It includes preventive, maintenance, and rehabilitative airway and breathing techniques and procedures. Such techniques may include the administration of medical gases and aerosols, continuous artificial ventilation, and other related airway management.

Social Day Care

Social day care is a structured program which provides functionally impaired individuals with socialization, supervision and monitoring, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance. This is for individuals that are not homebound and can participate in group setting activities.

Speech Therapy

Speech therapy (or Speech-Language Pathology) is the evaluation and treatment of speech or language disorders that result in communication or swallowing difficulties. You may be allowed up to 20 visits per year when provided in a setting other than a home (outpatient).

Telehealth

Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education care management and/or self-management of a member. For example, your Care Manager may authorize a machine that checks your heart rate and blood pressure and transmits the results to your doctor or nurse.

Transportation (Non-emergency)

A wheelchair van, taxi, public transportation, or non-emergent transport by ambulance may be arranged by the Care Management Team depending on your individual need for medically necessary trips, such as to dialysis or medical appointments. If you need a family member or personal care attendant to ride with you, they can go with you at no cost to you. If public transportation is available and you are well enough to travel to your medical appointments, we will reimburse you for the cost with prior approval by your Care Manager. If you need a ride to your health care visits, please call your Care Management Team or Member Services toll free at 1-866-843-7526.

Please set up a ride for non-emergency transportation **at least three days before your visit**. If the situation is urgent, please call your Care Manager or Member Services for assistance.

Services NOT Covered by Elderwood Health Plan

(If you have Medicare benefits, your membership in Elderwood Health Plan does not affect your Medicare eligibility or coverage. You will continue to receive services not covered by Elderwood Health Plan through your current Medicare providers. You do not need prior authorization from Elderwood to receive services covered by Medicare.)

Although the services listed below are not part of the Elderwood Health Plan benefit package, your Care Manager will help arrange and coordinate them as needed. Please contact Elderwood if you receive any of these services.

The following services are **NOT** covered by Elderwood Health Plan but are covered by Medicare or Medicaid on a fee-for-service basis:

- Ambulance
- Inpatient, Outpatient, and Emergency Room Hospital Services
- Physician Services

- Laboratory Services
- Chiropractic Care
- Chronic Renal Dialysis
- Medication - Prescription/Nonprescription
- Office for People with Developmental Disabilities (OPWDD) Services
- X-Ray/Radiology Services
- Rural Health Clinic Services
- Mental Health Services
- Alcohol and Substance Abuse Services
- Family Planning Services
- Hospice Services

Emergency Care

In the event of a medical emergency, **call 911. Prior authorization is not needed for emergency care.** Emergency Care is needed for sudden onset of a condition that poses a serious threat to your health or body function. *After the medical emergency, your family or friend should contact your care management team within 24 hours, if possible, so we can offer whatever help we can.* We may need to adjust your Service Plan to meet any changes in your medical needs. *If you are hospitalized, a family member or other caregiver should contact us within 24 hours of admission. It is very important for us to know this so we can cancel your scheduled home care services. Please be sure to tell the hospital discharge planner to contact Elderwood Health Plan so that we may work with them to plan your services for discharge from the hospital.* Emergency care is covered under your primary insurance and not paid for by Elderwood.

Hospitalization: If you are hospitalized, a family member or other caregiver should contact Elderwood Health Plan within 24 hours of admission. It is very important for us to know this so we can cancel the home care services you are getting at home for the time you are in the hospital (suspend service). Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your hospital discharge planner to contact Elderwood Health Plan so that we may work with them to plan your care upon discharge from the hospital and replace the services you need at home. Inpatient hospital care is covered under your primary insurance and not paid for by Elderwood.

Ambulance: **If you have a medical emergency, call 911.** You do not need a prior authorization for an emergency. Use of emergency transportation must be for emergencies only. Your primary insurance covers emergency transportation.

GETTING THE SERVICES YOU NEED

Service Plan

As part of your enrollment in Elderwood Health Plan, you will be assigned an experienced Care Manager who will help customize your service plan (plan of care) to meet your needs. Your Care Manager will be your main point of contact for all issues pertaining to the services you receive. Your service plan will include benefits that are covered and are deemed medically necessary along with services that may not be covered. You are encouraged to, and will have the opportunity to, take part in establishing your service plan, as will your health care providers and others you authorize to be part of the care planning process.

Elderwood encourages the support of your family or other caregivers in developing a service plan that will fit your needs. In addition, your service plan may include non-covered services and any other services provided by other providers, community resources and informal supports that your Care Manager will help you arrange.

You will receive your individual, person-centered service plan in writing. Your service plan will include a list of services that are authorized to be provided, including how frequently you will need these services, and the duration of time these services will be authorized. Services are offered 24 hours a day, seven days a week.

All services must have prior authorization unless there a need for medical emergency care. ***[Emergency Care is needed for sudden onset of a condition that poses a serious threat to your health or body function.]*** Your person-centered service plan addresses your personal goals and your health and safety risk factors. A registered nurse of the Elderwood Health Plan team will come to your home to reassess your needs and adjust your service plan. **All members are assessed twice a year and when there is a significant change to your health status.** This is required as part of your enrollment with a MLTCP.

Should you wish to discuss a change in your service plan, you should contact your Care Manager by calling Member Services at 1-866-843-7526. Care Managers or a Member Services specialist can assist you with information regarding your service plan, confirm service authorizations, and address other issues or concerns you may have.

Prior Authorization

Prior Authorizations are needed for most services you receive through Elderwood Health Plan coverage. This means that if you need any of the services listed below, you must get approval in advance, before receiving care. Your Care Manager should be informed of all the services you are receiving or planning to obtain. The authorization process helps to get the services paid for and to update your service plan. Prior Authorization is needed for all services with the exception of seeing a podiatrist, ophthalmologist, dentist, or audiologist for basic service such as an evaluation or repair. You can self-refer to these providers but your Care Manager can help you make arrangements for these services. The services that always require authorization in advance are:

- Home Care Services, including nursing care, social work services, rehabilitation therapies, nutritional counseling, and home health aide services
- Personal Emergency Response System (PERS)

- Adult Day Services
- Home Delivered Meals
- Outpatient Rehabilitation Therapy
- Chore or Housekeeping Services
- Audiology Services (for more than evaluation and basic service)
- Home Safety Modifications
- Respiratory Therapy and Oxygen
- Podiatry (for more than evaluation and basic service)
- Specialized dental procedures (root canals, crowns, dentures – through Healthplex)
- Medical and Surgical Supplies
- Nursing Home Care

Requesting New or Additional Services

Requests for new or additional covered services can be obtained through your Care Manager, by you or your provider, on your behalf. Requests can be verbal or in writing. New or additional services require the review and authorization of your Care Manager. Some requests require a medical necessity determination to ensure that the requested service is most appropriate for your condition and is medically needed. Requests for new or additional services will be handled in one of the following ways:

Prior Authorization (New Services)

A request by you or a provider on your behalf for a new service, or a request to change your service plan for a future authorization period, is a prior authorization

Retrospective Review

If you have Medicare or receive care or services without Elderwood knowing about it, we may do a retrospective review. That means that we will review your care after you have already received it. We use this information to make sure you are getting high quality care and that your benefits are being used correctly. Elderwood Health Plan is always a secondary payer to Medicare.

**Duration and frequency of services will be outlined in your individual service plan. You or your provider can request to amend the duration or frequency of covered services. Elderwood will make a clinical determination and will inform you and your provider in writing.

If the services you requested are not authorized, you will receive a Notice of Plan Action Letter by mail which will explain the decision. You or your provider may appeal the decision rendered by Elderwood. For more information, please refer to the Grievances and Appeals section of this handbook.

There may be instances other than true emergencies where prior authorization is not needed. To verify if prior authorization is necessary, check with your Care Manager.

Ombudsman Services

An ombudsman or public advocate is an individual or agency that represents the interests of the public. The Participant Ombudsman in New York State is an independent organization that provides free ombudsman services to long term care recipients. At this time, the Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN). ICAN can provide you with the following:

- General information regarding Medicare, Medicaid and long-term care programs
- Assistance in choosing a health plan
- Assistance with questions regarding your rights
- Assistance in resolving any issues related to access to care
- Help with filing a grievance or appeal
- Information on requesting a fair hearing and assist you through the process
- Information about community based resources and services that might be of benefit to you

All of the services provided by ICAN are free and confidential. ICAN is not connected with Elderwood Health Plan or any other health plan. To reach the Independent Consumer Advocacy Network (ICAN, please call (844) 614-8800, or for hearing and speech impaired, please dial 7-1-1 to reach NY Relay.

Nursing Home Transition to Home/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 to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

COMPLAINT AND APPEAL PROCESS

Elderwood Health Plan 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 Elderwood Health Plan 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: 1-866-843-7526 or write to: *Elderwood Health Plan Attn: Complaint and Appeals, 500 Seneca Street, Buffalo, NY 14204*. 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 Elderwood Health Plan 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 1-866-843-7526 or write to: *Elderwood Health Plan Attn: Complaint and Appeals, 500 Seneca Street, Buffalo, NY 14204*. 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.
- 2. 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).
- 3. 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.
 - a. 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,
 - b. 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.

MEMBER RIGHTS AND RESPONSIBILITIES

Members' Responsibilities

In order for you to get the best service possible, and as an Elderwood Member, it is your responsibility to:

- Learn and understand each Right you have under this Managed Long Term Care
- Ask questions if you do not understand your Rights.
- Know the name of your Primary Care Physician (PCP) and your Care Manager.
- Know about your health care and the process for getting care.
- Use providers who are in the Elderwood network of providers for services covered by this plan.
- Get approval from your Care Manager or Care Management Team, as required, before getting a service covered by Elderwood Health Plan.
- Understand emergency services are needed for sudden onset of a condition that poses a serious threat to your health or body function and not for care your primary care physician can provide.
- Contact your Care Management Team any time you have a change in, health condition or receive new health services.
- Contact your Care Management Team any time you have a change in your personal information.
- Treat the health care professionals who are giving you care respectfully.
- Tell Elderwood about your care needs, concerns, questions, or problems.
- Participate in managing your own health by telling your provider about your health care concerns and needs.
- Notify Elderwood when you go away or out of town.
- Make all required payments to Elderwood, if applicable.
- Follow your Care Manager's advice or talk to your Care Manager if you are unable or are unwilling to follow the Service Plan.
- Protect your member ID card and show it when you get service.
- Contact your Care Management Team or Member Services toll free at 1-866-843-7526 right away if your address or phone number changes.

Member's Rights:

As a member of Elderwood you are entitled to your rights. We encourage you to know and use your rights listed below:

- You have the right to be treated with respect and dignity.
- You have the right to receive medically necessary care.
- You have the right to request to change your Care Manager.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand and you can get oral translation services free of charge.

- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the right to be told where, when and how to get the services you need from your managed long-term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the right to appoint someone to speak for you about your care and treatment.

What Are Advance Directives?

Advance directives are legal documents that make sure your wishes about your medical care and treatment are followed in the event you are unable to make decisions for yourself. It is your right to make 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. Please contact your Care Manager for assistance in completing these documents. New York State recognizes three types of advance directives:

1. **New York State Health Care Proxy Form**

- a. This is a written form that lets you name a particular family member or friend (health care agent) to make decisions on your behalf if you cannot make them yourself.
- b. The health care proxy takes effect only after two doctors decide you are not able to make your own decisions.
- c. Elderwood can provide you with a state form and help you complete it.

2. **Living Will**

- a. This lets you say in writing, now, what health care and treatments you want, or do not want, in advance of situations where you may be unable to make important health care decisions on your own.
- b. It takes effect in the event you are unable to make your own decisions.
- c. You can find samples of the living will on the Internet or you can ask us for a copy.
- d. You can also write special instructions on your New York Health Care Proxy Form.
- e. It is your choice whether you wish to complete an Advance Directive and which type of Advance Directive is best for you. You may complete any, all or none.
- f. The law forbids discrimination against providing medical care based on whether or not a person has an Advance Directive.

3. Cardio-Pulmonary Resuscitation (CPR) and Do Not Resuscitate (DNR) Orders

- a. This tells health care providers and emergency workers whether you wish to be revived if you stop breathing or your heart stops beating.
- b. It takes effect when it is signed by your doctor.
- c. You can find samples of the CPR/DNR order form on the Internet or you can ask us for a copy.
- d. You can also write DNR instructions on your New York Health Care Proxy Form.
- e. Hospitals may ask you to use the forms they use.
- f. Anyone not in a hospital can use a “Nonhospital Order Not to Resuscitate” form. If you are too sick to decide about a DNR, your health care agent or your closest family member can act on your behalf.

MOLST - Medical Orders for Life-Sustaining Treatment (MOLST)

Honoring patient preferences is a critical element in providing quality end-of-life care. To help physicians and other health care providers discuss and convey a patient's wishes regarding cardiopulmonary resuscitation (CPR) and other life-sustaining treatment, the Department of Health has approved a physician and nurse practitioner order form ([MOLST](#)), which can be used statewide by health care practitioners and facilities. MOLST is intended for patients with serious health conditions who:

- Want to avoid or receive any or all life-sustaining treatment
- Reside in a long-term care facility or require long-term care services; and/or
- Might die within the next year

Completion of the MOLST begins with a conversation or a series of conversations between the patient, the patient's health care agent or surrogate, and a qualified, trained health care professional that defines the patient's goals for care, reviews possible treatment options on the entire MOLST form, and ensures shared, informed medical decision-making. Although the conversation(s) about goals and treatment options may be initiated by any qualified and trained health care professional, a licensed physician or nurse practitioner must always, at a minimum: (i) confer with the patient and/or the patient's health care agent or surrogate about the patient's diagnosis, prognosis, goals for care, treatment preferences, and consent by the appropriate decision-maker, and (ii) sign the orders derived from that discussion.

The MOLST form is one way of documenting a patient's treatment preferences concerning life-sustaining treatment - providers may choose to use other forms. However, under State law, the MOLST form is the only authorized form in New York State for documenting both nonhospital DNR and DNI orders. In addition, the form is beneficial to patients and providers as it provides specific medical orders and is recognized and used in a variety of health care settings.

DISENROLLMENT: Leaving Elderwood Health Plan

Voluntary

You may voluntarily disenroll from the plan at any time, for any reason, by notifying Elderwood by speaking or writing to us. After you inform us of your desire to leave the plan, you will be asked to sign a Voluntary Disenrollment Form and we will notify the Department of Social Services. Elderwood will give you written notice confirming we received your intent to disenroll and you will be given an effective date for termination of your coverage. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you request disenrollment within the first ten (10) days of the month, your disenrollment usually will take effect on the first day of the next month.

If you ask to be disenrolled after the tenth of the month, your disenrollment may not take effect until the following month. You will receive written notification of the date of your disenrollment. Elderwood Health Plan will continue to provide covered benefits until the effective date of disenrollment and will make all necessary referrals to alternative services that will be no longer covered by Elderwood after the disenrollment date.

Please note that if you disenroll and you continue to need long-term care services you must join another Managed Long Term Care (MLTC) or Managed Care Plan. The Elderwood Care Management Team will assist you in transferring to another MLTC or Managed Care Plan. You will receive a letter from Elderwood telling you the date of your disenrollment. Elderwood will continue to manage the services you need until your Membership has ended or you enroll in another MLTC or Managed Care Plan.

Involuntary Disenrollment

You may be involuntarily disenrolled from the plan under limited circumstances.

Elderwood is required to end your coverage for any of the following reasons:

- You no longer reside in the Elderwood Service Areas of Erie, Niagara, Orleans, Genesee, Wyoming or Monroe Counties.
- You have been absent from the service area for more than thirty (30) consecutive days.
- You are hospitalized or have entered an Office of Mental Health, Office for People with Developmental Disabilities (OPWDD), or Office of Alcohol and Substance Abuse Services residential program for 45 days or longer.
- You require nursing home care, but are not eligible for institutional Medicaid.
- You are no longer eligible to receive Medicaid benefits.
- You are not eligible for MLTC because you have been assessed as no longer requiring community-based long term care services or, for non-dual eligible enrollees, no longer meet the nursing home level of care as determined on your last assessment, using the assessment tool prescribed by the Department of Health (DOH)
- You are incarcerated

Elderwood Health Plan may initiate involuntary disenrollment if:

- You, your family, or other person in your home engages in conduct or behavior that seriously impairs our ability to provide services to you or another member.

- You (or your legal guardian) fail to pay for or make satisfactory arrangements to pay Elderwood the amount, as determined by the LDSS as spend-down/surplus or Net Available Monthly Income (NAMI).
- You fail to complete and submit any necessary consent or release.
- You provide Elderwood Health Plan with false information, or otherwise deceive Elderwood.
- You engage in fraudulent conduct with respect to your membership.

Involuntary Disenrollment Steps

Re-Enrollment

If you voluntarily disenroll from Elderwood, you will be allowed to re-enroll in the plan if you meet the eligibility criteria for enrollment. If you are involuntarily disenrolled from Elderwood and you wish to re-enroll, Elderwood will review the reasons for your involuntary disenrollment to determine eligibility for re-enrollment.

CONFIDENTIALITY FOR YOU

It is the policy of Elderwood Health Plan and we are committed to protecting your confidentiality and that of your family. This is done by:

- Making sure all information in your member record is confidential. Our staff protects against accidental release of information by safeguarding records and reports from unauthorized use.
- Arranging for all requests for information to be reviewed by our Compliance Officer to protect your right to privacy. Only necessary information will be shared with community agencies, hospitals, long-term care facilities, and other providers to ensure the continuity. Before being involuntarily disenrolled, Elderwood Health Plan will obtain the approval of the LDSS.
- If your situation requires us to disenroll you, we will contact you.
- You will get a letter from us telling you why we think you have to be disenrolled. The letter will tell you what to do if you disagree.
- We will notify you of the date that the disenrollment will take effect. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed.
- We will provide your covered services until the effective date of disenrollment.
- If you continue to need community based long-term care services, you will be required to choose another MLTC plan, or you will be auto-assigned by the Department of Social Services to another MLTC to provide you with coverage for needed services.
- and coordination of your care.
- Allowing only legally authorized representatives of our plan to inspect and request copies of your medical record and other records of the covered services provided to you, according to the written consent which you will have been asked to sign authorizing Elderwood to release such information.
- Following all federal and New York State laws regarding confidentiality, including those that relate to HIV testing results.
- Maintaining all records relating to you for a period of not less than seven (7) years after your disenrollment. Your medical and financial records are, and will remain, the property of Elderwood, except in accordance with applicable state and federal law, regulations, and the plan policy and procedures.
- Ensuring that the proper authorization is obtained prior to providing any information, when the law requires it.

NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices (this “Notice”) describes how protected health information (“PHI”) about you may be used or disclosed, your rights regarding PHI, information regarding how you may gain access to your PHI, and the legal duties of Elderwood Health Plan, LLC (Elderwood) to protect member PHI.

HIPAA Privacy Regulations

This Notice follows the requirements of Privacy Regulations set forth in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The HIPAA Privacy Regulations require companies such as Elderwood to follow the terms of the Privacy Regulations and of this Notice.

The Privacy Regulations define PHI as:

1. Information that identifies or can be used to identify a member
2. Information that either comes from the member or has been created or received by a health care provider, a health plan, the member’s employer, or a clearinghouse
3. Information that has to do with the physical or mental health or condition of a member, provision of health care to a member, or payment for provision of health care to a member.

Representation

You have the right to request a personal representative to act on your behalf, and Elderwood will treat that person as if the person were you. Please be aware, however, that unless you have applied restrictions, your personal representative will have full access to your entire PHI. You must make a request in writing if you would like someone to act as a personal representative. Please contact Member Services for more information at 1-866-843-7526.

Our Pledge Regarding Health Information

We understand that medical information about you and your health is personal. We are committed to protecting your medical information. We create a record of the care and services you receive through Elderwood. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice.

Changes to this Notice

- We reserve the right to change this notice.
- We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.
- A new notice that includes the changes and new effective dates will be mailed to you at the address in your medical record.
- You may also request a copy by calling Member Services at 1-866-843-7526.

In addition, we will update the information on the Elderwood website.

How We May Use and Disclose Your Medical Information

The following categories describe different ways that we use and disclose PHI without authorization:

1. To assist in the coordination of medical treatment and services on behalf of a member.
2. When updating a member's service plan.
3. So that services received by a member may be reviewed for payment.
4. In order to make decisions about claims requests and appeals for services provided to members.
5. To contact a member for an appointment reminder.
6. For health care operations, such as using the information in a medical record to review the care and results in a member's case, and other cases like it, for quality improvement.
7. To send members information about managing chronic conditions.
8. In order to answer a customer service request.
9. In connection with an investigation into any fraud or abuse cases, and to make sure required rules are followed.
10. To contract with Business Associates who will provide services to Elderwood using a member's PHI. Services of our Business Associates may include document management services or a software vendor.
11. Business Associates will only use member PHI to do the job we have asked them to do.
12. All Business Associates must sign a contract to agree to protect the privacy of member PHI.
13. Elderwood will provide Business Associates with changes to this notice.
14. To a family member, other relative, close friend, or other personal representative that a member chooses. The extent of the disclosure of the PHI will be based on how involved the chosen person is in a member's care, or payment that relates to a member's care.
15. If law enforcement officials ask us to disclose the information, such as an order to respond to a subpoena.
16. For public health activities allowed or required by law, such as disease control.
17. When requested by researchers when an institutional review board or privacy board has followed the HIPAA information requirements.
18. To identify a deceased person, determine a cause of death, or to perform other coroner or medical examiner duties allowed by law.
19. To share information with funeral directors, as allowed by law, as well as organizations that handle organ donation and transplants.

20. If we feel it is needed to prevent or reduce a serious and likely threat to the health or safety of a person or the public.
21. If a member is an organ donor, for the release of minimally necessary member PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
22. If a member is or was in the Armed Forces, for activities believed necessary by appropriate military command authorities.
23. To share PHI with the Secretary of the U.S. Department of Health and Human Services. This happens when the Secretary looks into or decides if Elderwood is in compliance with the HIPAA Privacy Regulations.
24. When required to, we will obtain your authorization before disclosing any of your information.
25. Except with regard to disclosures for treatment, only the minimally necessary information will be revealed during any disclosures.

Rights Regarding Your Medical Information

You have the following rights regarding medical information we maintain about you:

- You have the right to inspect and obtain a copy.
- You have the right to view and get a copy of your enrollment, claims, payment and care, management information on file with Elderwood. This file of information is called a designated record set. Elderwood will provide you with one copy of your designated record set in any 12-month period without charge. If you would like a copy of your PHI, you must send a written request to:

Elderwood Health Plan
Member Service Department
500 Seneca St., Suite 100
Buffalo, NY 14204

- We will answer your written request in thirty (30) calendar days but please understand that the request may take up to sixty (60) days to process.
- Elderwood **does** not keep complete copies of your medical records. If you would like a copy of your medical record from a certain provider, such as your podiatrist, you must contact that provider. That provider will instruct you on how to obtain a copy of your medical record and costs related to obtaining that record.

Right to a list of Certain Disclosures of Your Protected Health Information

You have the right to know how often your PHI has been disclosed. We keep a list of times we shared your information when it was not part of payment and health care operations. We are not required to account for routine disclosures, including disclosures to you or disclosures you have authorized. Most disclosures of your PHI by us or our Business Associates will be for payment or health care operations. If you would like to know how often your PHI has been

disclosed, please contact the Member Services Department for a request form. All requests for an accounting of PHI disclosures must be made in writing. Elderwood will provide you with one copy of your designated record set in any 12-month period without charge. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Confidential Communications

You have the right to ask that we communicate with you in a specific way or in a certain location. For example, you may ask that we send mail to an address that is different from your home address. You may request a form to change your contact information by calling Member Services at 1-866-843-7526. Requests must be made in writing.

Right to Receive a Copy of This Notice

You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. To request a copy of this notice, you must call or write Member Services.

Right to Request Restrictions and Limitations of Use

Although it is Elderwood Health Plan policy to make only minimally necessary disclosures of your PHI, you have the right to request a limit on how many times PHI is used. You have the right to request a restriction on the people who are able to obtain the information we disclose.

However, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

All requests must be in writing. You may request the form to restrict PHI use by calling or writing Member Services.

Right to Cancel a Privacy Authorization for the Use or Disclosure of Protected Health Information

You have the right to cancel a privacy authorization for the use or disclosure of your PHI. You must provide us with written authorization to use or give out your PHI for reasons other than those listed above.

INFORMATION AVAILABLE UPON REQUEST

The following information will be made available to you upon request:

- Information regarding the structure and operation of Elderwood Health Plan.
- Specific clinical review criteria relating to a particular health condition and other information that Elderwood Health Plan considers when authorizing services.
- Policies and procedures on protected health information.
- A written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Our provider credentialing policies.
- A recent copy of the Elderwood Health Plan certified financial statement.
- Policies and procedures used by Elderwood Health Plan to determine eligibility of a provider.

FRAUD AND ABUSE

Unfortunately, there may be a time when a participant or provider does something dishonest when dealing with Elderwood. This can be fraud and abuse.

Some examples of *provider* fraud and abuse are:

- Billing members for covered services (other than your copayments).
- Offering gifts or money for services.
- Offering free services or supplies to use your Elderwood ID card number.
- Giving services you do not need.
- Abuse by medical staff.

Some examples of *member* fraud and abuse are:

- Selling or lending your Elderwood ID card to someone else.
- Trying to get drugs or services you do not need.
- Forging or changing prescriptions.

Call Member Services at 1-866-843-7526 to report suspected fraud or abuse. You do not have to give your name when you report fraud or abuse. You can also contact NYDOH Fraud Complaint Line at 1-800-663-6114.