

MANAGED LONG-TERM CARE PLAN

MEMBER HANDBOOK



EVERCARE
C H O I C E



EverCare Choice
Managed Long Term Care Plan

31 Cerone Place | Newburgh, New York 12550
877.255.3678 [toll-free] | 845.569.0500 [tel] | 845.569.1887 [fax]

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IMPORTANT NUMBERS | CONTACT INFORMATION

Name	Phone/Email	Address
EverCare Choice	Phone: (845) 569-0500 Toll Free: (877) 255-3678 Fax: (845) 569-1887 TTY: (845) 569-2228 Website: www.evercare.org	EverCare Choice 31 Cerone Place Newburgh, NY 12550
Member Services	Call the main number and press 0 at any time.	
Your Care Team	Call the main number, then use the following prompts: (1) MLTCP Then: (6) Blue Team (7) Green Team (8) Orange Team (9) Red Team	
Non-Emergent Transportation	Call the main number, then use the following prompts: (1) MLTCP Then: (3) Transportation	
Equipment/Supplies	Call the main number, then use the following prompts: (1) MLTCP Then: (4) DME/Supplies	
Emergency Medical Services	911	
Corporate Compliance Hotline	(844) 371-4700	
NYS Department of Health Bureau of Managed Long Term Care (complaints)	(866) 712-7197	
New York Medicaid CHOICE (Maximus)	(888) 401-6582 (888) 329-1541 (TTY)	

If you are **hearing impaired**, we can help. We have written materials and sign language available.

If you are **vision impaired**, we can help. We have a large print Member Handbook. Our staff members can also read to you.

If you **do not speak or read English**, we can help. We have free interpretation services. Please let any member of the team know you would like an interpreter. Se habla Español.

Exceptional Care. Extraordinary Hearts.

At EverCare Choice, we are committed to providing uncompromised, compassionate PeopleCare. This means that in all that we do, we put the fact that we serve people first.

Guided by our core belief that everyone deserves to receive care in a nurturing, compassionate environment, we are committed to:

- Maintaining no-compromise standards of excellence in healthcare and peoplecare
- Setting a Standard of Excellence in the delivery of care
- Conducting all business in accordance with the highest ethical principles
- Upholding the trust given to us by our members
- Focusing on our core value of caring for our members, our community, and each other
- Providing exemplary physical, emotional and whole-person care for each of our members
- Acknowledging that the employees of an organization create its success
- Promoting well-being in our community through providing education in wellness and disease/illness management and prevention
- Exhibiting stewardship in the management of our employees, clinical staff, operations, and resources to maximize the quality of care, while minimizing the total cost of care
- Fostering a nurturing employee and clinical staff environment which embraces accountability, flexibility, personal & professional growth, and respect of each person's unique strengths and contributions
- Partnering with local academic and educational knowledge leaders to foster an environment of continual growth, development, and enrichment among our staff
- Embracing change, thinking outside the box, and challenging established assumptions

In one word, we are committed to *Excellence*.

In all that we do.

For our Members, our Community, and our Employees.

We commit to never losing sight of the fact that we were founded in the faith that we could make life better for the people whose lives we touch, whether they are our Members, their families, or our Employees. Community came first when our doors first opened, and Community will remain first as we grow.

Sincerely,



Sylvia McTigue
President | Chief Executive Officer

Welcome to EverCare Choice! Your health and satisfaction are important to us. We have created this Member Handbook to help you. Use it to understand the services available to you during your enrollment. Please feel free to contact our Member Services Department or your Care Management Team if you have any questions regarding covered services.

WHAT WE DO

EverCare Choice is a voluntary Medicaid Managed Long-Term Care Plan [MLTCP] serving Dutchess, Orange, and Rockland counties. We have a contract with the State of New York to coordinate your healthcare services. Our covered services are offered at no cost to you. Our goal is to help you remain safely in your home for as long as possible. We are dedicated to providing a personalized approach to maintain your dignity, independence, and quality of life. We can help you with things that may have become difficult for you, or that you are no longer able to do on your own.

Like many of our Members, you may have many health concerns. In order to keep you as healthy as possible, we monitor changes in your health. This allows us to help prevent problems, to detect problems early, and to get you the right care when you need it. There may be times in which you need more care that we can give you at home. If this happens, we can still help you. We have a network of nursing homes that you can stay in for as long as you need, either for a short time or permanently. You will still keep your Care Manager, who will continue to work with you, your family, and your caregivers to best meet your needs.

By choosing to join EverCare Choice, you agree to receive all of your covered services through our **Provider Directory**. Providers in our network have agreed to work closely with our Care Managers. This ensures that you receive the services you need (see Covered Services on page 12). Please see our Provider Directory for a listing of all participating providers.

HOW TO USE THIS HANDBOOK

This Handbook is made to be a quick reference to help explain the Plan and how to access your services. Keep this Handbook somewhere safe, where you will remember where it is. You should also share this Handbook with loved ones who may help you identify and communicate your needs. This Handbook is available on our website if you need a copy to share.

We have made every effort to make this Handbook easy to understand. If for some reason you need assistance, please don't hesitate to call us. A Member Service Representative will be happy to help you or provide you with additional information.

OUR AVAILABILITY

Our offices are open Monday-Friday from 8:30 a.m. to 5:00 p.m. We are available 24-hours a day, 7 days a week. If you need help outside of business hours, call our regular number. Your call will be directed to our on-call service.

VOLUNTARY MEMBERSHIP & YOUR ID CARD

We hope that you are pleased with your experience with EverCare Choice. Membership is voluntary, and there are other MLTC Plans that you could join. If you have not yet enrolled in EverCare Choice, you are free to decide not to enroll. Just call your Assessment Nurse and let him/her know that you have decided not to enroll. They will help you understand your options and what to do next. Also, once you are enrolled, you can choose to disenroll for any reason. If you are dissatisfied with your services or care, please contact your Care Manager to discuss what we could do differently. If, at the end of that discussion, you still wish to disenroll, please let your Care Manager know and we will begin the disenrollment process right away.

Throughout your enrollment, you will use your Member ID much the same way you would use your Medicare, Medicaid, or other Insurance Cards. We recommend that you keep it with your other Insurance Cards. This will make it easy for you to find and use it. By giving this card to your Providers, you help streamline your care. Replacement cards are available by calling the Member Services Department. Please make every effort not to misplace your card.

 EVERCARE CHOICE	COVERED SERVICES REQUIRE PRE-AUTHORIZATION <small>See Reverse Side</small>	COVERED SERVICES <ul style="list-style-type: none">• Skilled nursing, home health & personal care aides• Transportation to and from medical appointments• Nutritional evaluation & planning• Home-delivered meals• Physical, occupational, & speech therapies• Dental, vision, audiology, and podiatry services• DME/Supplies• Social/Medical Day Care
John D. Doe	Member Since: 11.01.15	Mail claims to: EverCare Choice, attn: Claims, 31 Cerone Place, Newburgh, NY 12550
Member ID 9999	Plan Type: MLTC	
Member Services (877) 255-3678 Office Hours M-F 8:30 a.m. – 5:00 p.m.		

CHANGE OF INFORMATION

We must have your current contact information. If we don't have it, you may miss important announcements from us. Please contact Member Services if you change your phone number or address.



TO MAXIMIZE YOUR MEMBERSHIP:

- ✔ Always bring your Member ID with you to appointments and let your Physician know you are a Member of EverCare Choice
- ✔ Always call Member Services or your Care Team if you are wondering if a service is covered or have a question
- ✔ Always call your Care Management Team to discuss your care needs
- ✔ Always notify EverCare Choice if you are admitted to the hospital or go to the ER

SECTION II | Eligibility & Enrollment

THE ADVANTAGES OF ENROLLING IN EVERCARE CHOICE

We want to help you maintain your independence for as long as possible. To do this, we offer, provide and/or arrange long-term care and other health services. Some advantages of enrolling in EverCare Choice are:

- ✔ We have a long history of service to the community and older adults
- ✔ Our staff are hired because they care. They will know and understand your personal health care needs
- ✔ Your family and caregivers will receive support in their efforts to keep you at home
- ✔ We will develop a care plan - with input from you, your family and caregivers - that identifies your specific needs
- ✔ You can keep your physician as long as he or she is willing to work with us
- ✔ Your Medicare benefits will not change. We will help coordinate these benefits, making it easier for you
- ✔ As long as you meet enrollment criteria, your enrollment continues as long as you desire, even if your health changes

ELIGIBILITY REQUIREMENTS

The State of New York mandates that residents that are dual eligible (eligible for both Medicaid and Medicare) and over twenty-one (21) years of age and have been determined to be eligible for Long Term Placement in a nursing home or reside in the community and are in need of community based long-term care services for more than 120 days and your nursing home or residence is located in the counties of Rockland, Orange or Dutchess, among others, you must enroll in a Managed Long Term Care Plan (“MLTCP”).

You may voluntarily enroll if you are age eighteen (18) through twenty (20) and you are dual eligible and have been assessed as eligible for nursing home level care and as needing community based long-term care services for more than 120 days; or if you are only Medicaid eligible and

age eighteen (18) and older and have been assessed as eligible for nursing home level of care and as needing community based long-term care services for more than 120 days.

Enrollment in EverCare Choice is voluntary, and there are other MLTC Plans that you could join. In order to be eligible for enrollment in EverCare Choice, you must be:

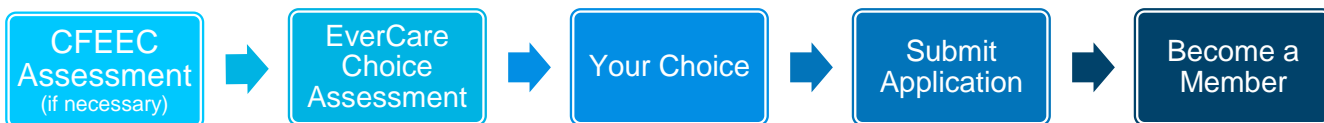
- ✔ At least 18 years of age
- ✔ A resident of and living in Dutchess, Orange, or Rockland County
- ✔ Eligible for Medicaid (as determined by your Local Department of Social Services)
- ✔ Eligible for the Plan, as determined by the eligibility assessment tool designated by the State of New York Department of Health
- ✔ Determined eligible for Long Term Placement in a nursing home or living in the community and capable of returning to or remaining in your home without jeopardy to your health and safety at time of enrollment if you are currently living in the community
- ✔ In need of long-term care services and care management from EverCare Choice for greater than 120 days. You must need—and receive—at least one of the following services from EverCare Choice to qualify for initial and ongoing enrollment:
 - Nursing services in the home
 - Private duty nursing
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Consumer Directed Personal Assistance Services
 - Skilled nursing care in a network facility

If you are enrolled in another Medicaid program, you may not be eligible for EverCare Choice. A Plan representative can help you if you are enrolled in another Medicaid program.

If you currently belong to a Mainstream Medicaid Managed Care Plan, you will need to complete additional paperwork with your Physician. You will also need at least one of the following services:

- ✔ Social Day Care
- ✔ Social & Environmental Supports
- ✔ Home Delivered Meals

ENROLLMENT PROCESS



For most applicants, the first step toward enrollment in an MLTC Plan is an assessment through New York Medicaid CHOICE’s *Conflict Free Enrollment & Evaluation Center* [CFEEC]. The purpose of

this assessment is to screen you for basic eligibility. The nurse who does this assessment is not employed by EverCare Choice.

Once the nurse decides you meet basic eligibility requirements, he or she will tell you about your choices. If you are ready to choose a plan, they will help you contact the MLTCP of your choice. If you wish to enroll in EverCare Choice, tell the nurse and he/she will help you contact us.

We will consider your application in the order it was received, regardless of your health status or need for services, or the amount we will receive from the Department of Health to provide your care.

What to expect during your initial assessment...

A member of our team will contact you to set up an appointment with one of our Assessment Nurses within thirty (30) days of your contact with us or through the referral from an enrollment broker. You are free to invite family/caregivers to be a part of this meeting. During this appointment, one of our Assessment Nurses will come to your home to evaluate you. He or she will assess you with forms approved by New York State. Below are examples of the information that will be gathered:

- ✔ Home safety evaluation
- ✔ How you are functioning with every day activities
- ✔ Medicaid eligibility information
- ✔ Personal identifying information, such as Medicaid card, Medicare card (if applicable), Social Security card and other information such as date of birth, marital status and so on
- ✔ Medications and treatments you are currently receiving
- ✔ Medical equipment used or needed

During this visit, the nurse will also discuss an initial Service Plan with you. If you are already receiving services, we will keep them in place for at least 90 days, unless you want them changed. If you do not already have services, the nurse will explain your options and what happens next. Your Service Plan will tell you which services you are authorized to receive, including how much and how often you will receive them. You will receive a copy of your initial Service Plan, including any changes that will happen after 90 days if you already have services in place.

We will also review and explain the following:

- ✔ Advance Directives and Health Care Proxy
- ✔ Your responsibilities as a Plan member
- ✔ How services are approved and changes made to the care plan
- ✔ The Member Handbook
- ✔ Provider Directory

ENROLLMENT & AGREEMENT ATTESTATION

At the end of your initial assessment, you will be given a choice if you wish to enroll. If you do, you must sign an Applicant Enrollment Agreement/Attestation. This form says that you understand everything that was discussed with you. It says you agree to abide by the rules of EverCare Choice, as

explained in this **Member Handbook**. It also says that you are voluntarily enrolling. We will leave a copy of this form with you.

Once you sign this form, we will submit your application for enrollment. Once your application is processed and approved, you will be notified of your actual enrollment date. Please feel free to contact our Member Services Department at (845) 569-0500 at any time during your enrollment process if you have questions or would like an update.

Please note that the Plan is not able to approve your enrollment. Enrollment is approved by your Local Department of Social Services or by New York Medicaid CHOICE. We must abide by certain timeframes. Your Assessment Nurse will explain these timeframes if they will affect your enrollment.

INELIGIBILITY

If the Assessment Nurse determines that you are not eligible, he or she will explain why and give you information about other care options. You can ask that we still submit your application, but we will recommend that it is not approved. We will send you a letter explaining why you were not submitted for enrollment.

Likewise, if your application is not approved, we will send you a letter. The letter will tell you why you were not enrolled. It will also tell you how to appeal the decision.

WITHDRAWAL OF APPLICATION

You are free to withdraw your application during the enrollment process but no later than noon on the 20th day of the month prior to the effective date of enrollment. All you need to do is let us know, verbally or in writing. We will process your withdrawal and send you a letter confirming your withdrawal.

If you decide to withdraw and you are eligible for both Medicare and Medicaid, you will have to choose a different MLTC plan in order to continue to receive long-term home care services. You are no longer able to receive these services through fee-for-service Medicaid. If you do not choose a Plan, one will be assigned to you by the State of New York.

If you decide to withdraw and are eligible for Medicaid only, you will have to choose one of the following:

- ✔ A different MLTC Plan
- ✔ A Medicaid managed care plan, or
- ✔ A waived service plan

in order to continue to receive home care services. You are no longer able to receive these services through fee-for-service Medicaid.

SECTION III | Your Services

Your enrollment becomes active on the 1st day of the month that you are enrolled. After this point, please make sure that you and/or your family and caregivers communicate your healthcare needs and any changes in your health to your Care Manager or Care Management Team.

Please call if you visit the Emergency Room or Urgent Care Center. Please also let us know if you are hospitalized. This allows for your Service Plan to be adjusted if necessary.



COVERED SERVICES AT A GLANCE

Your Assessment Nurse will determine your Person Centered Service Plan. They base their decision on what is medically necessary for you as an individual. If they are part of your Person Centered Service Plan, the following services are covered by EverCare Choice:

- ✔ Care Management and Coordination
- ✔ Nursing Home Care
- ✔ Home Care
 - Nursing
 - Home Health Aide|Personal Care Aide
 - Physical Therapy [PT]
 - Occupational Therapy [OT]
 - Speech Pathology [SP]
 - Medical Social Services
- ✔ Adult Day Health Care
- ✔ Consumer Directed Personal Care Services
- ✔ DME (including Medical/Surgical supplies, Hearing Aid Batteries, Orthotics and Orthopedic Footwear, etc.)
- ✔ Personal Emergency Response System [PERS]
- ✔ Non-emergent Medical Transportation
- ✔ Podiatry
- ✔ Dentistry
- ✔ Optometry|Eye Glasses
- ✔ PT, OT, SP or other therapies provided in a setting other than the home
- ✔ Audiology|Hearing Aides
- ✔ Respiratory Therapy
- ✔ Nutrition
- ✔ Private Duty Nursing
- ✔ Home Delivered or Congregate Meals
- ✔ Social Day Care
- ✔ Health care services that can be delivered using telehealth devices such as remote patient monitoring or two-way communication technologies
- ✔ Social and Environmental Support including the room and board for hospice care

All of these services must be pre-authorized by EverCare Choice. If you believe you need any of these services, please contact your Care Manager so he/she can help you.

Additionally, the Department of Health is in the process of implementing a program called Community First Choice Option (“CFCO”). Certain additional services are covered under the CFCO as long as you are at a Nursing Home Level of Care per the most recent assessment and can live safely in the community and you reside in your own residence or the residence of a family member. CFCO is a program that helps with various supports to assist you in living in the community. The benefits include, but are not limited to, moving assistance, environmental modifications to your home and to your vehicle and various types of assistive technology.

Money Follows the Person (MFP)/Open Doors

In addition, the state provides 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.

PROVIDER DIRECTORY

In order to access covered services, you must use a provider from the Provider Directory. The Provider Directory is made up of people and organizations who have agreed to work with EverCare Choice. If you are dissatisfied with a provider, please report it immediately and we will help you find another provider.

IF YOUR PROVIDER LEAVES EVERCARE CHOICE...

A complete listing of everyone in our Provider Directory will be given to you. You can also access our Provider Directory at www.EverCare.org. Updates will be made to the website on a regular basis. We recommend checking the Provider Directory on the website when choosing providers because it will be the most up-to-date. You will be notified in writing if any providers you currently use are removed from the directory.

If your provider no longer participates in our Provider Network, we will make sure your care is not interrupted. We will explain your choices to you and help you select a new provider or explain how to change to a MLTC Plan who works with your provider

DO NOT ATTEMPT TO GET COVERED SERVICES FROM SOMEONE NOT LISTED IN THE PROVIDER NETWORK without prior approval. They will not be covered by the Plan. However, if you are a new member, you can continue to use your existing providers if they are not in the Provider Directory for up to 90 days. In order for this to happen, your provider must accept Plan rates and must be willing to adhere to EverCare Choices quality standards. At the end of the 90 days, you must switch to a provider in the Provider Directory.



NON-COVERED SERVICES

Non-covered services are those services that will continue to be covered by Medicare or other health insurance. If you do not have Medicare, they may be covered by fee-for-service Medicaid.

You do not need pre-authorization from EverCare Choice to receive these services. However, we do encourage you and your physician to contact us to discuss your care needs. This allows for the best coordination of your care. You do not need to use providers in our Provider Directory for non-covered services.

Examples of non-covered services are as follows:

- ✔ Alcohol and substance abuse services
- ✔ Chronic renal dialysis
- ✔ Emergency transportation
- ✔ Family planning services
- ✔ Inpatient hospital services
- ✔ Laboratory services
- ✔ Mental health services
- ✔ Outpatient hospital services
- ✔ Physician services
- ✔ Prescription drugs
- ✔ Over-the-counter drugs
- ✔ Radiology
- ✔ Emergency Room visits
- ✔ Assisted Living Program

There are also services that are not covered by EverCare Choice or fee-for-service Medicaid. If you were to choose to get these services, you would have to pay for them yourself. Examples of these services are:

- ✔ Personal care and comfort items, such as wipes, creams and ready-washes
- ✔ Surgery that is not medically necessary, such as cosmetic surgery
- ✔ Infertility treatments

SERVICES RECEIVED OUTSIDE OF THE SERVICE AREA

Under normal circumstances, you will receive services within the service area (Dutchess, Orange, and Rockland counties). There may be times that you plan to be out of the service area for a short time (up to 30 days). When this happens, we will work with you to plan for your needs. We will try to use area providers for non-emergency covered services to the extent that we can.

If you are out of the service area for more than 30 days in a row, we must disenroll you. This is a requirement by the State of New York. We will send you a letter explaining this action.

If you have any change in health status or have received emergency medical or urgent care while you were out of the service area, please notify EverCare Choice as soon as possible. We will assist you in coordinating your care.

EMERGENCY SERVICES

Emergency services are not covered by the Plan and do not require prior approval. Medicare or fee-for-service Medicaid will pay for emergency services. Please update your Care Manager regarding any trips to the ER or Urgent Care so that we can make sure your Service Plan is updated.



If you believe you have an emergency
CALL 911
GO TO THE NEAREST EMERGENCY ROOM
OR PRESS YOUR PERSONAL EMERGENCY RESPONSE SYSTEM

YOUR PRIMARY CARE PHYSICIAN (PCP)

You can still use your trusted PCP. The only requirement is that he/she is willing to work with the Plan. We will work together closely to make sure you get the care you need.

If you do not have a PCP, your Care Manager can work with you to find one. We can also help you find a new one if your PCP does not want to work with the Plan. Your Care Manager can also help you find a specialty doctor if you need one.

IF YOU HAVE MEDICARE OR OTHER INSURANCE

If you have Medicare and/or Medicare Supplementary coverage, it does not change when you are a member of EverCare Choice. You do not need to use the Provider Directory when obtaining Medicare services.

If your Medicare coverage ends and EverCare authorizes services for you and you are not using a contracted provider in the Provider Directory, you will need to change providers to one that is in the Provider Directory. Your Care Team can help you do this.

DEFINITIONS OF COVERED SERVICES & GUIDELINES

Please note: most of our services are authorized based on Medical Necessity. *Medical Necessity* means that you must meet certain pre-determined criteria to receive a service. Sometimes you may have a preference, or maybe even find it helpful, but it may not be considered *medically necessary*. In those cases, the service or item will not be authorized.



All insurance companies, including fee-for-service Medicaid and Medicare, make coverage decisions based on *medical necessity*.

ADULT DAY HEALTH CARE

Definition: Day care and certain services provided in a residential health care facility under the direction of a physician. In order to attend a medical model day care, you have to meet certain eligibility requirements regarding your need for care. Your Care Manager can let you know if you meet these criteria.

Coverage: Determined based on medical necessity, in cooperation with your Primary Care Physician, as needed.

Unless the day care provides transportation, we will arrange transportation for you.

Limitations: You must have skilled or medical needs in order to attend a medical model day care. If you do not meet these criteria, you can be referred to a social model program. *Prior authorization is required.*

If you need to change your days of attendance, or wish to add days, either one time, or more, please contact your Care Manager for approval. Non-approved changes or additions will not be covered.

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for Adult Day Health Care. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

AUDIOLOGY | HEARING AIDS

Definition: Audiology services include audiometric examinations and testing, hearing aid evaluation, conformity evaluation, and hearing aid prescription. Hearing aid services include selecting, fitting and dispensing hearing aids, earmolds and batteries. Also included are hearing aid checks and repairs.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Hearing aids will be replaced upon the recommendation of an audiologist in the Provider Directory.

Hearing aids are limited to 1 pair per year. We will cover the cost of repairing broken hearing aids. We will replace lost or destroyed hearing aids.

Exclusions: Items not generally provided under Medicaid guidelines are excluded from coverage.

CARE MANAGEMENT SERVICES

Definition: Assists Members in accessing necessary covered services in support of your Patient Centered Service Plan.

Coverage: Available 24 hours a day, 7 days a week.

Limitations: None. Care Management services are provided by EverCare Choice staff members. All you need to do is call the Plan. We are here to help. The services include referral, assistance in or coordination of services to obtain needed medical, social, educational, psychosocial, financial and other services in support of the Person Centered Service Plan even if the needed services are not included in the Benefit Package.

CONSUMER DIRECTED PERSONAL ASSISTANCE SERVICES

Definition: Allows greater flexibility and freedom of choice in receiving your personal care services. Under this program, you choose, train, and direct a person of your choosing to deliver care. You have the opportunity to decide how, when and by whom your personal care needs are addressed.

Coverage: Determined based on medical necessity and in accordance with our approved time-task tool. This tool is based on your UAS score and specific care needs.

If you choose to have CDPAS, you must find and train your own aide. It is important for you to arrange for back-up care in case your aide cannot make it for any reason.

Limitations: Your Care Manager must determine you are eligible for CDPAS care. If you are not able to direct care yourself, you must have someone designated to do it for you. You are free to choose anyone to be your CDPAS aide, except for a spouse|parent or someone who is legally responsible for you.
Prior authorization is required.

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for CDPAS. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

DENTISTRY

Definition: Includes routine dentistry provided by a Dentist. Preventative services, routine exams, oral surgery, and dentures are covered.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Members are eligible for partial/full dentures 1 time every 8 years. If a member has broken their dentures (complete or partial), we will only pay for new ones when the existing ones cannot be repaired. Consistent with Medicaid guidelines, we will not pay to replace lost or stolen dentures.

Exclusions: Items not generally provided under Medicaid guidelines are excluded from coverage.

DURABLE MEDICAL EQUIPMENT [DME] & SUPPLIES

DURABLE MEDICAL EQUIPMENT

Definition: Durable Medical Equipment [DME] are devices and equipment which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

- ✔ Can withstand repeated use over a period of time
- ✔ Are primarily used for medical purposes
- ✔ Are generally not useful if you do not have an injury or illness; and
- ✔ Are not usually fitted, designed or fashioned for a particular individual's use. If the equipment is intended for use by only one patient, it may be either custom-made or customized.

Coverage: Determined based on medical necessity, in cooperation with your Primary Care Physician as needed. In general, Medicare/Medicaid guidelines are used to determine coverage. If you have Medicare coverage, then your Medicare insurance may be the primary insurance to cover the DME. DME may be rented or purchased, based on your need and what is most appropriate.

We or your Medicare insurer may cover the cost to repair or replace your DME items if they are non-working. The decision to repair instead of replace will be made by the Care Manager.

Limitations: In general, Medicaid guidelines, unless you have Medicare coverage and it covers the item, are used to determine coverage, including limitations on coverage. Below are the maximum allowables for some common items. *Prior authorization is required.*

- ✔ Hospital bed = 1 (maximum) every 5 years
- ✔ Mattress = 1 (maximum) every 2 years
- ✔ Gel mattress = 1 (maximum) every year
- ✔ Air pressure mattress = 1 (maximum) every year
- ✔ Nebulizer = 1 (maximum) per year
- ✔ CPAP device = 1 (maximum) every 5 years
- ✔ Walker = Can be received 1 (maximum) every 3 years if no other mobile device (such as a wheelchair) is used
- ✔ Standard Wheelchair = 1 (maximum) every 5 years
- ✔ Motorized Wheelchair = 1 (maximum) every 5 years
- ✔ Commode = 1 (maximum) every 5 years
- ✔ Raised toilet seat = 1 (maximum) every 5 years
- ✔ Tub bench = 1 (maximum) every 5 years
- ✔ Hoyer lift = 2 (maximum) in lifetime
- ✔ Prescription orthopedic footwear = 2 per year

Exclusions: Items not generally provided under Medicare/Medicaid guidelines are excluded from coverage.

MEDICAL/SURGICAL SUPPLIES

Definition: Items for medical use that have been ordered to treat a specific medical condition. They are usually:

- ✔ Non-reusable
- ✔ Disposable
- ✔ For a specific purpose

Coverage: Determined based on medical necessity. In general, Medicaid guidelines are used to determine coverage.

Limitations: In general, Medicaid guidelines are used to determine limitations on coverage. Your Care Manager will order the amount he/she feels is appropriate for your needs. Below are the maximum allowables for some common items. *Prior authorization is required.*

- ✔ Alcohol wipes = 5 boxes per month
- ✔ Lancets = 2 boxes per month
- ✔ Gloves = 1 box per month
- ✔ Briefs/pull-ups = 250 per month

Exclusions: Items not generally provided under Medicaid guidelines are excluded from coverage. If you are under the care of a CHHA, certain medical supplies may be provided by the CHHA.

HOME CARE SERVICES

HOME HEALTH AIDE | PERSONAL CARE AIDE SERVICES

Definition: HHA|PCA services are provided in the home under the supervision of a registered nurse or licensed therapist. Your aide provides assistance with personal hygiene, light housekeeping, and other supportive tasks with health care needs in the home. We encourage family and other informal means of support to remain active in the member's life to promote quality of life and home stability.

Coverage: Determined based on medical necessity and in accordance with our approved time-task tool. This tool is based on your UAS score and specific care needs. Once you have been identified as eligible for HHA|PCA services, your Care Management Team will assist in identifying a vendor to provide your services.

Limitations: HHAs and PCAs are only allowed to work on tasks as identified by your Care Manager in the Person Centered Service Plan. They are not allowed to be in your home when you are not present. They are not allowed to work extra hours without prior approval from your Care Manager. They are not allowed to care for other members of your family or household who are not Members of the Plan. *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home HHA|PCA services. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

MEDICAL SOCIAL SERVICES

Definition: Social Work services are provided by Social Workers or Social Work Assistants. The purpose is to provide support and to help link you to community resources.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home Medical social services. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays, unless such services are part of discharge planning.

NURSING SERVICES

Definition: Nursing services are provided in the home by RNs and LPNs. Nursing services may include direct care—such as pre-pouring medication or wound care—or supervision of aides.

Coverage: Determined based on medical necessity.

Limitations: Skilled Nursing Services must be ordered by your physician.

Prior authorization is required.

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home Nursing Care. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

OCCUPATIONAL THERAPY

Definition: OT services provided in the home by a licensed and registered Occupational Therapist. The purpose of the services is to restore you to your best level of functioning. Evaluation of performance, skills assessment, and treatment to improve your Activities of Daily Living are covered.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home Occupational Therapy services. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

PHYSICAL THERAPY

Definition: PT services provided in the home by a licensed Physical Therapist. The purpose of the services is to restore you to your best level of functioning. Examination, diagnosis, and treatment services are covered.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home Physical Therapy services. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

SPEECH LANGUAGE PATHOLOGY

Definition: SLP services provided in the home by a licensed and registered Speech Language Pathologist. The purpose of the services is to restore you to your best level of functioning. Evaluation and treatment of speech and language disorders are covered. Difficulties with feeding/swallowing are covered.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for in-home Speech Language Pathology services. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

HOME DELIVERED MEALS

Definition: Home delivered meals are for members who need help with meal preparation. They are used when a member can no longer prepare meals or use an oven or stove safely. They can also be used when a member is not eating healthy meals.

Coverage: Determined based on need when assigned PCA/CDPAS or available family/informal supports are unable to complete meal preparation.

Limitations: Home delivered meals are for the member only. Family members/aides/caregivers are not covered. Home delivered meal of lunch is not covered during periods in which the member is in a social or medical model day care, as lunch is served in these settings. *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for Home Delivered meals through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

NON-EMERGENT MEDICAL TRANSPORTATION

Definition: Non-emergent transportation is provided to all doctor's appointments, Day Centers, Dialysis, Mental Health appointments, and other trips deemed necessary by your Care Manager.

Coverage: Routine requests (doctors' appointments, day center attendance, dialysis, etc.), must be **booked 2 days in advance**. Non-routine requests (same day appointments) will be booked when possible, but there is no guarantee that a vendor will be available on such short notice.

Trips within the service area (Dutchess, Orange, and Rockland counties), do not need special approval from your Care Manager. However, **your vendor must still obtain prior approval from our transportation team.**

Limitations: Trips outside of the service area (other counties, other states, New York City, etc.) require prior approval from your Care Manager. Out-of-service-area requests must be **booked 1 week in advance** to allow the vendor plenty of notice, as trips out of the service area require extra preparation. Please note: not all vendors will make trips out-of-service area. You may be required to accept transportation from a different vendor than your usual vendor. We are required to provide only approved Medicaid ambulette vendors to provide ambulette transportation services. *Prior authorization is required.*

Exclusions:

- ✔ Emergency transportation (via an ambulance as part of an emergency)
- ✔ Non-medical transportation (shopping, errands, etc.)
- ✔ Trips without prior approval
- ✔ Drop-offs at any location other than your place of residence, appointment, or social/adult day center

NURSING HOME CARE

Definition: Our goal is to keep you safely in the community. When this is not possible, we authorize and pay for short term rehab and permanent placement in nursing homes in the Provider Directory. If there are no beds available in one of our contracted nursing homes, we must pay for you to go to another nursing home.

Coverage: Determined based on medical necessity.

Limitations: You must be eligible for institutional Medicaid. Permanent placement in a nursing home will only be authorized when it is not possible for you to remain safely in your home with support. This decision will be made in consultation with you, your physician, caregivers, and family. *Prior authorization is required.*

You are free to choose an out-of-network nursing home, but you must disenroll from EverCare Choice and re-enroll in a Plan that contracts with that nursing home.

NUTRITION

Definition: Includes the assessment of nutritional needs and food patterns, dietary planning, and nutrition counseling, provided by a qualified nutritionist.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for nutrition services through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

OPTOMETRY | EYE GLASSES

Definition: Services provided by an optometrist to include exams, eye glasses, medically necessary contact lenses, artificial eyes (stock or custom made) and low vision aids. The optometrist may perform an eye exam to detect visual defects or eye disease.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Unless medically justified in very specific cases, eye exams are limited to 1 per year. Eye exams including refraction are limited to 1 every 2 years.

Eye glasses are limited to 1 pair per year, and must be “Medicaid frames.” Eyeglass lenses may be changed more frequently in cases such as a rapidly changing cataract condition

We will replace lost or destroyed eyeglasses. The replacement for a complete pair of eyeglasses should duplicate the original prescription and frames.

Exclusions: Items not generally provided under Medicaid guidelines are excluded from coverage.

PERSONAL EMERGENCY RESPONSE SYSTEM [PERS]

Definition: A PERS is a device that allows you to get help in the event of an emergency. In general, you press a button that alerts the response center of your need for help.

Coverage: Determined based on medical necessity. Members benefit from PERS when:

- ✔ They live alone and/or can be alone for significant parts of the day
- ✔ They have no regular caregiver for extended periods of time
- ✔ They require extensive supervision or are at increased risk for falls
- ✔ They are able to understand when they need assistance and can follow directions to activate their PERS

Limitations: PERS may not be appropriate when:

- ✔ A Member is unable to recognize their need for assistance
- ✔ Cognitive/physical impairment would prohibit appropriate device use
- ✔ Those with live-in or 24-hour care may not be appropriate recipients of this service

Exclusions: Members permanently placed in a nursing home are not eligible for PERS. Once a decision to permanently place you has been made, your PERS service will be discontinued.

PODIATRY

Definition: Includes routine foot care provided by a Podiatrist. There must be an illness or injury involving the foot. Examples are diabetes, ulcers, or infections.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Exclusions: Routine hygiene care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition. Members staying in Skilled Nursing Facilities are not eligible for Podiatry services through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

PRIVATE DUTY NURSING

Definition: Skilled nursing care that is medically necessary and is continuously provided by properly licensed registered professional or licensed practical nurse. Private duty nursing services can be provided by a Licensed Home Care Services Agency.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for Private Duty Nursing services through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

RESPIRATORY THERAPY

Definition: Services provided by a qualified Respiratory Therapist. Includes preventative, maintenance, and rehabilitative care. Includes the application

of medical gases, humidity, and aerosols, intermittent positive pressure, continuous ventilation and the administration of drugs through the airway.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. *Prior authorization is required.*

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for respiratory therapy through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

SOCIAL DAY CARE

Definition: A structured day program which provides members with socialization, supervision and monitoring, personal care and nutrition in a protective setting during part of the day. Unless the day care provides transportation, we will arrange transportation for you.

Coverage: Determined based on medical necessity.

Limitations: Social day care is not appropriate for individuals with certain skilled or medical needs during the day. *Prior authorization is required.*

If you need to change your days of attendance, or wish to add days, either one time, or more, please contact your Care Manager for approval. Non-approved changes or additions will not be covered.

Exclusions: Members residing in Skilled Nursing Facilities are not eligible for Social Day Care through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

SOCIAL & ENVIRONMENTAL SUPPORTS

Definition: Services and items that support the medical needs of a member and are included in your Person Centered Service Plan. May include things such as home maintenance tasks, accessibility modifications, or respite care.

Coverage: Determined based on need and in support of the implementation of your Person Centered Service Plan.

Limitations: Supports must primarily benefit the member. All requests for social and environmental supports must be reviewed by the Utilization Review Committee prior to approval. *Prior authorization is required.*

Exclusions: Modifications to rental units without landlord's approval.

THERAPIES OUTSIDE OF THE HOME

Definition: PT, OT, SP or other therapies provided in a setting other than the home.

Coverage: Determined based on medical necessity.

Limitations: In general, Medicaid guidelines are used to determine coverage, including limitations on coverage. Limited to 20 visits of each therapy type per year.

Prior authorization is required.

Exclusions: Members staying in Skilled Nursing Facilities are not eligible for office-based therapies through the Plan. Authorizations will be suspended during hospice, respite, hospital and short-term rehabilitation stays.

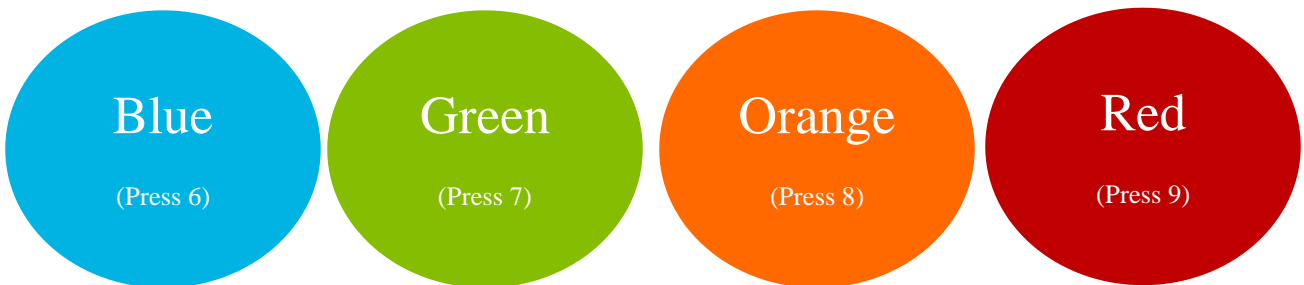
SECTION IV | Care Planning & Your Care Team

You, your family/caregiver, Physician, and EverCare Choice, are all partners in the success of your care. You, your family/caregiver, and Provider(s) will receive an annual satisfaction questionnaire. We strongly encourage you to participate and provide honest feedback related to the care and services you receive from EverCare Choice.

YOUR CARE TEAM

You will be assigned to a Care Team who will help you while you are enrolled in EverCare Choice. You will have a primary Care Manager, who will be a nurse or social worker. Each Team includes other Care Managers and Care Coordinators, too. This makes it easy for you to connect with someone when you need help...you have a dedicated team! This team is responsible for coordination of your care and for providing you with exceptional customer service. They will help you stay as independent and as healthy as possible.

To make things easy for you to remember, your team will be identified by a color. You will be on one of the following teams:



When you call the Plan, you can access your team by pressing the number to your team when directed by the phone prompts. Otherwise, you can just ask for your team color by name and someone can direct your call. In addition, EverCare has Transportation Coordinators and DME|Supply Coordinators who will help you when you need to book transportation for a medical appointment or when you need supplies or medical equipment. We also have social workers, who may help you with things like food stamps, paying your bills, or your Medicaid recertification. And our friendly Member Service Representatives can answer general questions or point you in the right direction if you don't know who to ask.

Just keep in mind...the most important person on your Care Team is

You!

Other things people from your Care Team may do include:

- Calling you or your family on a regular basis to see how you are doing and to ask about your satisfaction with your care
- Authorizing services for you based on medical necessity and help getting doctor's orders when needed
- Talking with your Primary Care Physician and other community resources to make sure your Person-Centered Service Plan is up-to-date
- Helping arrange covered services by working with providers in our Provider Directory
- Helping coordinate non-covered services

DESIGNATING A REPRESENTATIVE

It is important that we know from the start who you want involved in your care. Perhaps you have a spouse, child, or family member who helps you make decisions. Maybe it is a neighbor or trusted friend. It can be someone you have “officially” designated, like a Power of Attorney or Health Care Proxy, or it can be someone you have “informally” designated, like your spouse or friend. You can designate as many—or as few—people to be involved in your care as you like. Let a member of your Care Team know your wishes and give us contact information for those you want involved in your care.

We take your confidentiality very seriously. If you do not give us permission to speak to a family member, friend, or loved one, we will not share your information with them. This is why it is important to let us know your wishes, including if there are specific people you do NOT want us to talk to.



ADVANCED DIRECTIVES

A more formal way of designating a representative or expressing your wishes regarding your care is to designate an Advanced Directive. An *Advanced Directive* is a legal document that makes sure your wishes regarding your care are known and followed. There are a number of different kinds of

Advanced Directives. Your Assessment Nurse, Care Manager, or Social Worker can help explain the differences so that you can make an informed choice.

HEALTHCARE PROXY

- What it does: It allows you to choose who you want to make healthcare decisions for you if you are unable to make them for yourself. You tell this person what your wishes are and they act on your behalf. **You are choosing a PERSON to make decisions for you.**
- How to get one: New York State has a form that you can use. A member of your Care Management Team can get it for you if you wish. Your Care Team, or a trusted family or friend, can help you fill it out.
- Legal Involvement: You do not need a lawyer to designate a healthcare proxy. The document does not need to go through the court system.
- It takes effect: When 2 doctors have decided you can no longer make your own decisions.

LIVING WILL

- What it does: Lets you say ahead of time what you want—and what you do not want—at the end of your life. **You are NOT choosing a person to make decisions for you. You are explaining your wishes in advance.**
- How to get one: You can write special instructions on your Healthcare Proxy form or use a form of your choosing. A member of your Care Management Team can help you if you need a form.
- Legal Involvement: You do not need a lawyer to have a Living Will. The document does not need to go through the court system.
- It takes effect: When you can no longer communicate your wishes and your doctor decides that you have an incurable condition.

DNR [DO NOT RESUSITATE] ORDER

- What it does: Lets healthcare workers know that you do not wish to be revived if your heart stops beating or you stop breathing. **You are NOT choosing a person to make decisions for you. You are explaining your wishes in advance.**
- How to get one: You can write special instructions on your Healthcare Proxy form or use a Non-Hospital Order Not to Resuscitate Form. A Member of your Care Team can help you get this form
- Legal Involvement: You do not need a lawyer to have a DNR Order. The document does not need to go through the court system. You DO need to get a doctor's order to have a DNR.
- It takes effect: When your doctor signs the order.

POWER OF ATTORNEY

What it does:	A Power of Attorney is not really an Advanced Directive, but it does help determine how your care will be provided. A Power of Attorney identifies another person to make decisions for you if a court has determined you are unable to make decisions for yourself. A PERSON is chosen to make decisions for you.
How to get one:	Usually, someone else starts this process for you. If you have questions or need help, let a member of your Care Management team know.
Legal Involvement:	There is lawyer and court involvement in getting a Power of Attorney.
It takes effect:	When the Court indicates.

YOUR PERSON CENTERED SERVICE PLAN

Once you decide to become a Member of EverCare Choice, your primary Care Manager will meet with the Assessment Nurse who did your first home visit. They will talk about your home visit and the services your Assessment Nurse identified as medically necessary.

The Care Manager will also work with you to develop a Person Centered Service Plan that meets your needs. Your Person Centered Service Plan is based on your healthcare needs and includes both the services we will pay for and other things we may be coordinating for you, even if we will not be paying for it. Your Person Centered Service Plan will also include information about your care goals and your health and safety risk factors.

We will get information from you, your physician, and others involved in your care in deciding what to include in your Person Centered Service Plan. It is important that you take an active role in developing your plan. Your personal preferences are important.

At least once every 6 months, your Person Centered Service Plan will be reviewed to make sure the services you are receiving are meeting your needs. You, or your designated representative, will be involved in this review. An Assessment Nurse will come to your home to see you.

REQUESTING CHANGES TO YOUR SERVICE PLAN

Update your Care Manager regarding any hospitalizations, trips to the ER, or urgent care visits so that we can make sure your person centered service plan is updated.

Sometimes your care needs change. For example, you may need to change the days you receive personal care or day center attendance. When you need this kind of change, call your Care Team and discuss your needs with them. We will be happy to accommodate your changes when possible.

Other times, you may feel you need more or less of a service you are getting, or wish to add a service you do not currently have. When this is the case, we will consider your request based on your individual needs and medical necessity. Please see the section below, as well as the Definitions of Covered Services & Guidelines section for more information.

YOUR SERVICE AUTHORIZATIONS

Your Assessment Nurse or Care Manager will authorize your covered services in the amounts found to be medically necessary based on your current condition and health needs. The guidelines we use to determine whether or not something is medically necessary are based on the guidelines that Medicaid and Medicare use. We call these guidelines “Clinical Justification Guidelines.” They help us make wise decisions so that we can make sure that each Member gets the amounts and types of services that are appropriate to their condition and needs.

Most of our services require *prior authorization*.

Prior authorization means authorization that is gotten *before* a service is provided. Either you or a provider can request prior authorization of services. Your request will be reviewed according to the appropriate Clinical Justification Guidelines. We will make a decision within 3 business days of getting all of the information, but in no more than 14 days after we received your request. If you meet the guidelines an authorization will be sent to your provider letting them know we agree to cover the service. If you do not meet the guidelines, you and/or your provider will be sent a Notice of Initial Adverse Determination (see next section).

THE FOLLOWING SERVICES DO NOT REQUIRE PRE-AUTHORIZATION:

- ✓ 1 preventative dental exam per year
- ✓ 1 preventative eye exam per year
- ✓ 1 preventative audiology exam per year

You, or your provider, can also request a *concurrent review*. A **concurrent review** means a request to get more of a service you are already getting. Your request will be reviewed according to the appropriate Clinical Justification Guidelines. We will make a decision within 1 business day of getting all of the information, but in no more than 14 days after we received your request. If you meet the guidelines a new authorization will be sent to your provider letting them know we agree to cover more of the service. If you do not meet the guidelines, you and/or your provider will be sent a Notice of Initial Adverse Determination (see next section).

Whether you are asking for prior authorization or a concurrent review, you can ask for an [expedited decision](#) if you and/or your provider feels that a delay in our decision could jeopardize your health. We will let you know whether or not we will expedite your request, or ask for more information if we need it. If we expedite your request, we will give you an answer as soon as we can, but no more than 3 days after we receive the request.

Every time we approve a prior authorization or concurrent review, your Person-Centered Service Plan will be updated as appropriate.

NOTICE OF ACTION

ACTIONS

An *action* is any time EverCare Choice:

- 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 ends a service we have already authorized
- Denies payment for services
- Does not provide services in a timely manner
- Does not respond to a grievance or appeal in a timely manner

Every time we have an “action,” you have a right to be notified and to request an appeal.

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.

We notify you by sending you an “[Initial Adverse Determination Letter](#).” An Internal Adverse Determination letter 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. A description of the Action we have taken or intend to take

The notice will also tell you about your right to a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you do not have to file an appeal before asking for a Fair Hearing;
- It will explain how to ask for a Fair Hearing; and
- If we are reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

Section VI of this handbook provides further information about appeals and fair hearings.

You will receive an Initial Adverse Determination Letter even when you have asked us to change your services. When this is the case, or if you agree with our decision, you do not need to do anything when you receive the letter. You can file it with your other important papers.

GETTING HELP WITH APPOINTMENTS

Many Members prefer to make their own medical appointments or to have their family help them. We like to encourage all Members to be as independent as possible. However, if you need help in making and managing your appointments, we are here to help. Please call your Care Team to let them know when you need assistance making appointments.

PREVENTATIVE CARE APPOINTMENTS

Preventative care is a covered service for the following areas:

- Vision (optometry)
- Hearing (audiology)
- Teeth (dentistry)

All Members should have an annual preventative care exam in each of these areas. This allows for your doctor to notice problems early and recommend treatment right away. Your attendance at these important appointments is one of the questions you will be asked during your periodic evaluations from the Plan. If you need help setting up your preventative care appointments, please contact your Care Team and let them know. They will be happy to help.

SAME DAY APPOINTMENTS

Same day appointments are for situations in which you need to see your doctor the same day and cannot wait for the next available appointment. If you have unsuccessfully tried to get a same day appointment, call your Care Team for help. We will work with you, your provider, and other network providers to get your needs met.

TRANSPORTATION SERVICES

If you need a ride to your medical appointments within our service area, our friendly Transportation Coordinators can help. Routine requests must be made **at least 2 days before your appointment**. Same-day requests will be booked when possible, but there is no guarantee that a vendor will be available on such short notice.

Trips outside of the service area require approval from your Care Manager. Requests for out-of-service area transportation must be made **at least 1 week before your appointment**. Please understand that not all vendors are able to accommodate out-of-service area trips. In such cases, you may be required to use a new vendor. Your Care Team will be happy to help you find a provider in our service area to minimize transportation issues, including the amount of time you must spend getting to and from your appointments.

SECTION V | Your Rights & Responsibilities

MEMBER RIGHTS

The New York State Department of Health has granted you a number of rights as a Member of a Managed Long Term Care Plan. These are things that the Plan “owes” to you. It is EverCare Choice’s responsibility to support you in exercising your rights.

You have a right to:

- ✔ Be treated with respect and dignity
- ✔ Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion
- ✔ Appoint someone to speak for you about your care and treatment
- ✔ Receive medically necessary care
- ✔ Timely access to care and services
- ✔ Be told what you need to know to give informed consent about your care
- ✔ Take part in decisions about your health care, including the right to refuse treatment
- ✔ Get information in a language you understand; you can get oral translation services free of charge
- ✔ Get information on available treatment options and alternatives presented in a manner and language you understand

- ✔ 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
- ✔ Privacy about your medical record and when you get treatment
- ✔ Get a copy of your medical records and ask that the records be amended or corrected
- ✔ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- ✔ Complain to the New York State Department of Health or your Local Department of Social Services
- ✔ Use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate
- ✔ Seek assistance from the Participant Ombudsman program.

You may exercise any and all of these rights without fear of retaliation

MEMBER RESPONSIBILITIES

In the last section, we learned about your rights. Along with your rights, as a Member of a MLTC Plan, you also have responsibilities. These responsibilities are things that you “owe” the Plan. It is your responsibility to agree to:

- ✔ Tell the Plan about your care needs and concerns
- ✔ Use providers who work with EverCare Choice for covered services
- ✔ Get approval from your Care Manager or Care Team before receiving a covered service
- ✔ Tell the Plan when you go away or out of town
- ✔ Pay assigned Medicaid spenddown within thirty (30) days after such amount first becomes due
- ✔ Assist the EverCare Choice staff in developing and maintaining a safe home environment for you, your family and your caregivers
- ✔ Notify EverCare Choice promptly of any change in address. If you are planning to move, notice should be mailed to our office at:

EverCare Choice
31 Cerone Place
Newburgh NY 12550

- ✔ Comply with all policies of the program as noted in the Member Handbook
- ✔ Treat participating providers and EverCare Choice staff respectfully and courteously

VOLUNTARY DISENROLLMENT

Membership in EverCare Choice is voluntary. You are free to disenroll from the Plan at any time, for any reason. To do so, you may call us or send us a letter requesting disenrollment.

Once we receive your request to disenroll, we will send you a letter letting you know we got your request. We will then send your request to New York Medicaid Choice [Maximus] for processing. EverCare Choice cannot make the determination to disenroll you; only Maximus can make this decision. Once Maximus tells us you are disenrolled, we will notify you with a second letter indicating your final date of disenrollment.

Your disenrollment will be effective the 1st day of the month after Maximus processes your request. This is not always the 1st day of the month after you request disenrollment. If your request came in after the submission deadline, you will not be disenrolled until the following month. You will continue to receive covered services until the date of your disenrollment.

INVOLUNTARY DISENROLLMENT

EverCare Choice is required to initiate disenrollment of you within five (5) business days from when the Plan becomes aware that

- ✔ You no longer demonstrate a functional or clinical need for community-based long term care services
- ✔ You only receive Social Day Care services from the MLTC plan
- ✔ You do not meet the eligibility requirements as determined by the UAS (the tool New York State uses to determine eligibility)

EverCare is also required to disenroll you from the Plan if:

- ✔ You no longer live in Dutchess, Orange, or Rockland County
- ✔ You have been away from Dutchess, Orange, or Rockland County for more than 30 days in a row
- ✔ You are hospitalized for more than 45 days in a row
- ✔ You enter an OMH, OPWDD, or OSAS residential program for more than 45 days in a row
- ✔ You require nursing home care, but you are not eligible for nursing home care under Medicaid rules
- ✔ You are no longer eligible for Medicaid
- ✔ You are in jail

In addition, EverCare Choice may decide to disenroll you for the following reasons:

- ✔ You or your family member behaves in a way that impairs our ability to provide services to you or other Plan Members
- ✔ You do not pay your spenddown/surplus payment. Before disenrolling you, will we try to work out a satisfactory plan for you to pay your spenddown/surplus
- ✔ You do not complete a required consent or release
- ✔ You provide us with false information or engage in *fraudulent behavior*. An example of fraudulent behavior would be if you sign off that your PCA or CDPAS aide was present in your home when they were not

To begin the disenrollment process, we will inform you by sending you a letter. You will continue to receive covered services until the date of your disenrollment.

PAYMENTS TO THE PLAN

Your monthly payment responsibility will depend upon your eligibility for Medicaid and Medicaid’s spend down requirements:

If you are eligible for...	You Pay...
Medicaid (no spend down)	Nothing to EverCare Choice
Medicaid (with spend down)	A monthly spend down payment to EverCare Choice as determined by LDSS A surplus payment if you are in a nursing home

If your Medicaid spend down payment changes while you are an EverCare Choice member, your payment will be adjusted.

PAYMENTS

If you are required to pay spend down, you will receive a bill from EverCare Choice every month. Payment of your Medicaid spend down can be made by check or money order to:

EverCare Choice
 ATTN: Finance Office
 31 Cerone Place
 Newburgh, NY 12550

DISENROLLMENT FOR NON-PAYMENT OF MEDICAID SPEND DOWN

Payment of your spend down is a requirement of continued enrollment in the Plan. If you fail to pay your required spend down, we will send you a letter advising you of late payments and that disenrollment may result for non-payment.

If you have been notified that you will be disenrolled because you failed to pay the monthly Medicaid spend down, you can avoid being disenrolled simply by paying the Medicaid spend down. The payment must be made before the 14th of the month of your disenrollment. For example, if you have been notified you will be disenrolled July 31st, you must pay your spend down by July 14th to safely avoid disruption of coverage.

If you wish to disenroll from EverCare Choice, you must enroll in another MLTC Plan, Managed Care Plan, or Waiver Program to continue to receive community-based long term care services.

IF YOU GET A BILL FROM A PROVIDER

When you use a provider from the Provider Directory for approved services, you should not get a bill. These providers have agreed to bill EverCare Choice an agreed-upon amount for your care. These providers have also agreed not to bill you, even if EverCare Choice does not pay for the bill, or if we only pay for part of the bill.

There may be times when you might have to pay for a bill. For example:

- When you receive services from an out-of-network provider without getting permission first
- When you receive services that are not authorized by EverCare Choice

If you have received a bill you do not think you should have gotten, call your Care Team and we will assist you.

CORPORATE COMPLIANCE

EverCare Choice has a Corporate Compliance Program. This program outlines rules and expectations for staff and providers. We expect the Board of Trustees, staff, and all providers to behave in a trustworthy manner. We also expect people to follow laws, regulations, and policies.

We have a Corporate Compliance Committee that monitors EverCare Choice's consistent application of the rules of our compliance program.

If you have any compliance concerns, you can call our hotline at 1-844-371-4700. This hotline is confidential and you will be able to leave a message about your concern. If you want us to get back to you about your concern, please be sure to leave your name and a call back number.

GIFT POLICY

Part of providing you with exceptional services involves making sure we do things in an ethical manner. This includes making sure we follow laws and regulations. To help us do this, we have a Code of Ethics that helps our staff understand how to make decisions at work.

Our Code of Ethics tells our staff that they are not allowed to receive gifts from our Members. No one should ever feel that they have to give our staff gifts to get good care.

We do understand that you may feel very grateful for the care and services you receive. Instead of giving our employees, or employees of one of our providers, a gift, we ask that you send a note of thanks to our office. We will make sure that the staff sees this note, and that everyone is able to take part in having your satisfaction noted and celebrated.

Please understand that if you do give an employee a gift, they are required to decline it. It is not that they do not appreciate your gratitude. They are following our Code of Ethics.

Examples of gifts could be:

- ✔ Money
- ✔ Meals
- ✔ Transportation
- ✔ Entertainment (movie tickets, Broadway tickets, etc.)
- ✔ Personally bought gifts (jewelry, clothing, coffee machines, etc.)
- ✔ Hand-made gifts

If one of our employees, or an employee of one of our providers, asks you for a gift or if you believe their conduct is unethical, please call our Corporate Compliance Officer without delay. Call the Hotline at 1-844-371-4700. You may leave a confidential voicemail message with the employee's name and details of occurrence. The information will be kept in strictest confidence.

If you have any questions regarding this policy, please call the Corporate Compliance Officer directly at 845-725-1117.

CONFIDENTIALITY

EverCare Choice takes your privacy very seriously. We make sure that only appropriate people have access to your information. In order to protect your confidentiality:

- ✔ We follow all State and Federal laws and regulations regarding confidentiality, including HIPPA, HITECH, and those related to HIV Confidentiality
- ✔ You will receive a written copy of our Privacy Practices upon enrollment
- ✔ We will ask you to sign a release so that we can share information with those involved in your care. This includes friends, family members, and others of your choosing
- ✔ The information in your record is confidential. We take special steps to make sure your information is safe. This includes both your physical records and your electronic records
- ✔ If someone requests information from your record, our Corporate Compliance Officer will review the request to make sure it is appropriate
- ✔ When we must share information with a vendor, provider, hospital, or someone else, we share the least amount possible to ensure you receive the care you need

NOTICE OF PRIVACY PRACTICES

You will get a complete copy of our Notice of Privacy Practices when you enroll with the Plan. The summary below includes key points.

During the course of providing service and care to you, EverCare gathers, creates, and keeps certain personal information about you that:

- ✔ Identifies who you are
- ✔ Relates to your past, present, or future physical or mental condition
- ✔ Relates to the provision of health care to you
- ✔ Relates to payment for your health care services

This personal information is characterized as your “protected health information.” The Notice of Privacy Practices tells you about the possible uses and disclosures of such information. It also tells you about your rights with respect to your protected health information [PHI].

We will require a written authorization from you before we use or disclose your protected health information. An exception of this would be when we are required or permitted by law not to get written authorization first. We have a form for you to use to authorize us to share your information. If you change your mind about the authorization, you must let us know in writing.

You have the following rights regarding your PHI:

- ✔ To see and copy your PHI. In some cases, EverCare may deny your request as permitted by law. However, you may be given an opportunity to have such denial reviewed by an independent licensed health care professional
- ✔ To request that we update or change your PHI. If we deny your request, we will send you a letter that tells you why and tells you what to do if you disagree
- ✔ To request that we limit the use and disclosure of your PHI. EverCare is not required to honor your request, but if we do, it will comply with your request except in an emergency situation or until the restriction is ended by you or EverCare
- ✔ To request that EverCare communicate PHI to the you by alternative means or at alternative locations
- ✔ To receive an accounting of disclosure of your PHI created and maintained by EverCare. Please see the Notice of Privacy Practices for detailed information
- ✔ To request and receive a copy of EverCare’s Notice of Privacy Practices for PHI in written or electronic form

FRAUD WASTE & ABUSE

When a Member or a Provider does something dishonest regarding dealings with EverCare Choice, it is called fraud, waste or abuse. Fraud and abuse are against the law.

Some examples of fraud, waste or abuse by a **Provider** include:

- ✔ Billing you for authorized services covered by EverCare Choice
- ✔ Billing EverCare Choice for services they did not provide
- ✔ Giving you services that you do not need

Some examples of fraud, waste or abuse by a **Member** includes:

- ✔ Signing your PCA or CDPAS aide’s time sheet when they did not work the hours
- ✔ Selling medical supplies that you receive from the Plan, or giving them to someone else
- ✔ Letting someone else use your EverCare Choice ID to get services

EverCare Choice has zero tolerance for fraud, waste and abuse. If you suspect fraud, waste or abuse, you should call the Plan and report it. If you wish to make an anonymous report, you can call our Corporate Compliance hotline at (844) 371-4700.

Members found to be guilty of fraud, waste or abuse will be disenrolled from the Plan.

COMPLAINT RESOLUTION

We want to know if you are not happy!

EverCare Choice will try our best to deal with your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you are experiencing.

There will be no change in your services or the way you are treated by EverCare staff or a health care provider because you file a grievance or an appeal. We will give you any help you may need to file a grievance 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.

GRIEVANCE PROCESS

A *grievance* is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. Grievance is another word for complaint. 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 grievance with us.

You may file a grievance verbally or in writing. The person who receives your grievance will record it, and appropriate Plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance and a description of our review process.

We will review your grievance and give you a written answer within one of two timeframes.

- If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information
- For all other types of grievances, 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 grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

TO FILE A GRIEVANCE

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

Verbally: (845) 569-0500 You may speak with any staff member

In Writing: EverCare Choice
Attention: Member Services
31 Cerone Place
Newburgh, NY 12550

COMPLAINTS TO NEW YORK STATE

At any time, you may contact the New York State Department of Health to file a complaint.

Verbally: (866) 712-7197

In Writing: NYS Department of Health
Bureau of Managed Care Certification and Surveillance
Complaint Unit Room 1911
Corning Tower ESP
Albany, NY 12237-0062

APPEALS

If you do not agree with a decision that EverCare Choice has made regarding your care, you can ask for the decision to be reviewed.

INTERNAL APPEALS

GRIEVANCE APPEALS

If you are not satisfied with the decision we make concerning your grievance (complaint), you may request a second review of your issue by filing a grievance appeal. An *appeal* means that we will look at your case again. You must file a grievance appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your grievance.

- 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 grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, who were not involved in the initial decision.

We will adhere to the following timeframes regarding your appeal:

- 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 grievance appeal process. For expedited grievance appeals, we will make our appeal decision within 2 business days of receipt of necessary information.

For both standard and expedited grievance 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.

ACTION APPEALS

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 business days of the date on our letter notifying you of the action.

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 how we will handle it. 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.

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.)

If you chose to go through EverCare Choice’s Internal Appeals process you may request to continue to receive the services you have while your internal appeal is pending and the Plan may choose to continue your services, but it is not required for the Plan to do so.

If we deny your request for services or deny it in part and modify the services, you will receive a letter explaining your rights to appeal the Internal Appeal Determination.

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. 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 appeal is expedited we will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days 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.)

TO REQUEST AN APPEAL:

Verbally: Call us at (845) 569-0500 and ask to speak to Utilization Review

In Writing: EverCare Choice
Attn: Appeals
31 Cerone Place
Newburgh, NY 12550

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 EverCare 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.”

STATE FAIR HEARING

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides your appeal and then ask for a Fair Hearing. In either case, the same 60 calendar day deadline applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending, or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing an internal or external appeal will not guarantee that your services will continue.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear that you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. In all cases, you must make your request within 10 days of the date on the notice, or by the intended effective date of our action (whichever is later).

Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; 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. 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.

TO REQUEST A FAIR HEARING:

Verbally: 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)

Online Form: <https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx>

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

To Fax Form: (518) 473-6735

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

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

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

TO REQUEST AID CONTINUING:

If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a Fair Hearing to continue to receive these services while your appeal is decided. We must continue your service if you ask for a Fair Hearing 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.

So, for example, if you got a Notice of Action dated August 1st (*Date of Notice*), with your change in services beginning August 11th (*date the action is going to take place*), you would need to let us know that you were requesting *aid continuing* before August 11th. If we do not hear from you before the 11th, in this example, your services would be changed as of August 11th.

If you did not request a Fair Hearing but rather chose to go through EverCare Choice's Internal Appeals process you may request to continue to receive these services while your internal appeal is pending and the Plan may choose to continue your services, but it is not required for the Plan to do so.

To find out how to ask for a Fair Hearing, and to ask for aid to continue, see the Fair Hearing Section.

Although you may request a continuation of services, if the Fair Hearing 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.

SURVEYS & MEMBER INPUT

EverCare Choice is committed to providing you with the best possible experience. Your input is an important part of our continued growth and improvement.

We welcome your feedback at any time, either verbally or in writing. This includes positive feedback about your experience, as well as feedback for improvement. Our staff are eager to hear your comments.

MEMBER EDUCATION

EverCare Choice provides on-going education to you through various methods such as newsletters, website columns, and counseling and health care meetings on topics, such as:

- ✓ Injury prevention;
- ✓ Domestic violence;
- ✓ HIV/AIDS, including availability of HIV testing and sterile needles and syringes;
- ✓ STDs, including how to access confidential STD services;
- ✓ Smoking cessation;
- ✓ Asthma;
- ✓ Immunization;
- ✓ Mental health services;
- ✓ Diabetes;
- ✓ Screening for cancer;
- ✓ Chemical dependence;
- ✓ Physical fitness and nutrition;
- ✓ Cardiovascular disease and hypertension;
- ✓ Dental care, including importance of preventive services such as dental sealants;
- ✓ Screening for Hepatitis C for individuals born between 1945 and 1965.

INFORMATION AVAILABLE UPON REQUEST

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

- ✓ A listing of the names, business addresses, and official positions of our Board of Trustees, officers, and controlling persons
- ✓ Our policies and procedures for protecting your confidentiality and medical records
- ✓ A written description of our Quality Plan
- ✓ Our clinical justification guidelines or other information we use in our utilization review process
- ✓ Information about our organizational structure and operations
- ✓ A copy of our most recent certified financial statement
- ✓ Policies and procedures we use to credential our network Providers