MANAGED LONG-TERM CARE PLAN

MEMBER HANDBOOK

EVERCARE CHOICE

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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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] Dutchess County [7] Orange County [8] Rockland County [9] New Member or Congregate Care Setting	
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] 71 2–7197	
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 Espanol.

**This handbook will be submitted for approval by the NYS Department of Health if it includes a proposed service change.*

Exceptional Care. Extraordinary Hearts.

Guided by the principles of quality, respect, excellence, ethics and integrity, we care for our community through uncompromised commitment to compassionate PeopleCare.

In addition, in order to provide quality driven, person–centered, integrated care to all who entrust us to guide their individualized care in the comfort of their home or place of residence, 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
- Focusing on our core value of caring for individuals, our community, and each other
- Providing competent and exemplary care
- Acknowledging that the employees of an organization create its success
- Promoting well–being in our community through a delivery service that focuses on disease/illness management and prevention
- Exhibiting stewardship in the management of our employees, clinicians, operations, and resources to maximize the quality of care, while minimizing the total cost of care
- Fostering a nurturing employee environment which embraces accountability, competence, excellence in all we do, flexibility, personal & professional growth, and respect of each person's unique strengths and contributions
- 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 belief that we can 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 continue to grow.

Welcome to EverCare Choice. We are thankful that you have chosen us as your Managed Care Plan.

Sincerely,

Sylvia McTigue
President | Chief Executive Officer

SECTION I | MLTCP Overview

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 where you can receive nursing home care. 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 your covered services through our providers that are listed in the **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.

EverCare Choice honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

We have made every effort to make this Handbook easy to navigate. If for some reason you need assistance, please do not 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. but 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 will be pleased with your experience with EverCare. 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 explain your options and what you need 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 changes can be made. 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.

CHANGE OF INFORMATION

We must have your current contact information. If we do not 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 personalized care plan – with input from you, your family and caregivers – that identifies your specific needs
- You can keep your physician, if the physician participates in EverCare Choice's network
- 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
- In addition to making certain we deliver services in the language you require, we will also treat you in a culturally competent manner. This means that we maintain an inclusive, culturally competent provider network and we honor your religious and cultural beliefs
- EverCare shall not unlawfully discriminate in access to enrollment or provision of services on the basis of age, sex, race, gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services, place of origin, or with regard to the capitation rate the contractor will receive.
- EverCare must operate the program in compliance with all applicable state and federal non–discrimination laws.

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 reside in the community and are in need of community based long–term care services such as, nursing and therapies in the home, personal care services in the home, home health aide services, consumer directed personal assistance services and/or adult day health care for more than 120 days and your 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 a continuous period of 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 a continuous period of 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
- Is capable at the time of enrollment of returning to or remaining in your home without jeopardy to your health and safety if you are currently living in the community
- In need of community based 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

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 are being disenrolled from another MLTC Plan due to an approved service area reduction, closure, acquisition, merger, or other approved arrangement, the Plan must continue to provide services under the Enrollee's existing Person–Centered Service Plan for a continuous period of 120 days after enrollment or until the Plan has conducted an assessment and the Enrollee has agreed to the new Person–Centered Service Plan.

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.

Conflict Free Evaluation and Enrollment Center [CFEEC] is the entity that contracts with the Department to provide initial evaluations to determine if an Applicant is eligible for Community Based Long Term Care [CBLTC] for a continuous period of more than 120 days. The CFEEC will be responsible for providing conflict–free determinations by completing the Uniform Assessment System [UAS] for Applicants in need of care. CFEEC evaluations are conducted in Your home [including hospital or nursing home] by a Registered Nurse. 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 and prior to enrollment, the nurse will also discuss an initial Person–Centered Service Plan with you. A proposed Person–Centered Service Plan will be left with you. If you are already receiving community based long term care services, we will keep them in place at the same level, scope and amount for at least 90 days, even if they are a transfer from another plan, unless you want them changed. If you do not already have services, the nurse will explain your options and what happens next. Your Person–Centered Service Plan will tell you which services you are authorized to receive, including how much and how often

you will receive them. Based upon the findings from the assessment, a Person–Centered Service Plan will be developed. You will receive a copy of your initial Person–Centered Service Plan [or one from a reassessment] within fifteen [15] days of enrollment or reassessment. The completed Person–Centered Service Plan must be signed by You. You must be a part of the development of the plan and You may select individuals such as your providers or informal support system to participate in service planning and delivery.

It will also include any changes that will happen after 90 days if you already have services in place.

Please note that if you have been transferred from another MLTC due to an approved service area reduction, closure, acquisition, merger or approved arrangement, then your Person–Centered Service Plan will be continued for 120 days after enrollment or until the Plan has conducted a new assessment and you have agreed to the new Person–Centered Service Plan.

We will also review and explain the following:

- Advance Directives, Health Care Proxy and Back–up Caregiver Agreement
- The HIPAA release form
- Your responsibilities as a Plan member
- How services are approved and changes made to the care plan
- Notify You that the Consumer Directed Personal Assistance Program is an available voluntary benefit.
- Inform You that if You are not self–directing, a designated representative will be identified to assume Consumer Directed Personal Assistance Service responsibilities and that representative cannot be your personal assistant
- The Member Handbook

We will retain in each enrollee's record documentation that the Enrollee received the information and notifications required.

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. The Enrollment Agreement 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 the Enrollment Agreement with you.

Once you sign the Enrollment Agreement, 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 Enrollment is approved by New York Medicaid Choice [NYMC]. We must abide by those decisions and timeframes. Your Assessment Nurse will explain these timeframes if they will affect your enrollment.

Also, if you have been transferred from a New York State MLTCP that is no longer in business, you may be enrolled without a prior assessment.

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. If your application is not approved, we will send you a letter. The letter will tell you why you were not enrolled. NY Medicaid Choice [NYMC], the enrollment broker, will also provide you with denial letter which will include fair hearing rights and tell you how to appeal the decision. Likewise, if CFEEC establishes that you are eligible but our assessment finds that you are not eligible, the issue will be resolved by the NY Medicaid Choice.

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 residing in the community and 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 waivered 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.

TRANSFERS

If you want to transfer to another MLTC Medicaid Plan. You can try us for 90 days. You may leave EverCare Choice and join another health plan at any time during that time. If you do not leave in the first 90 days, you must stay in EverCare Choice for nine more months, unless you have a good reason (good cause). Some examples of Good Cause include:

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving EverCare Choice is best for you.
- Your current home care provider does not work with our plan.

- We have not been able to provide services to you as we are required to under our contract with the State

If you qualify, you can change to another type of managed long term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. EverCare Choice will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in EverCare Choice.

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 some of the services covered by EverCare Choice:

- Care Management and Coordination
- Nursing Home Care
- Medical Social Services
- Personal Care Services
- Home Care services such as
  - Nursing
  - Home Health Aide [HHA]
  - 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, Enteral and Parenteral Formula limited to gastrogastric, jejunostomy, or gastrostomy tube feeding or treatment of an inborn error of metabolism, Hearing Aid Batteries, Prosthetics, 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 are limited to 40 visits of PT and 20 visits each for OT, SP and other therapies per calendar year, except for individuals under 21 and the developmentally disabled. Plan may determine that additional visits are needed.
- 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
- Social and Environmental Supports

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.

Please note that the Plan may provide cost–effective services or settings that are an alternative to these services and settings as long as approved by the NYS Department of Health and permitted by law.

Money Follows the Person [MFP]/Open Doors

In addition, Money Follows the Person [MFP] means a demonstration that is part of Federal and State initiatives designed to rebalance long term care services, and promote consumer choice. As New York State continues to shift the focus of its long term care systems away from institutional care and towards integrated home and community–based care, support from the MFP program becomes valuable to all Managed Care Organizations [MCO's]. MFP is designed to streamline the process of deinstitutionalization for vulnerable populations. Under the name Open Doors, the MFP program funds Transition Specialists and Peer Support to assist these individuals to transition out of institutions such as nursing homes and intermediate care facilities, and into qualifying community settings. A qualified setting may be a house, an apartment, or a group home [with a maximum of four unrelated people].

This program 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.

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 you need a paper copy of the Provider Directory, please contact Member Services at 877.255.3678 [toll–free] | 845.569.0500 [tel].

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 transferring from another plan, 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 Medicaid 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
- OPWDD Services
- Chronic renal dialysis
- Emergency transportation
- Family planning services
- Inpatient hospital services
- Laboratory services
- Mental health services
- Outpatient hospital services
- Physician services

- Prescription and Non–Prescription Drugs, Compounded Prescriptions, Over–the–counter drugs
- Radiology
- Emergency Room visits

IF YOUR PROVIDER LEAVES EVERCARE CHOICE…

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

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 are outside of the service area and urgently needed services are required, these services will be covered. If you plan to be out of the service area for a short time [up to 30 days], please contact the plan so we can assist you with 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.

Emergency condition means you reasonably expect that without immediate medical attention you are placing your health, physical or behavioral, in serious jeopardy; or you may suffer serious impairment to a bodily function; or serious dysfunction to a bodily organ or part of you; or serious disfigurement and because of this danger to life or health, require use of the most accessible hospital available and equipped to furnish those services.

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. 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. 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*.

LONG TERM SERVICES AND SUPPORTS OR [LTSS]

Definition: Long Term Services and Supports or [LTSS] means health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses who require assistance with routine daily activities such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of community–based services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, Personal Care Services, and institutional services including Long Term Placement in Residential Health Care Facilities

Coverage: Determined 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, batteries, special fittings and replacement parts. 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. This ensures that You have access 24 hours per day, seven days a week for information, emergency consultation and response in the community, if necessary.

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: means the provisions of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant. Under this program, you or your designated representative, hire, train, supervise, direct and, if necessary, fire a person of you or your designated representative's choosing to deliver care. Personal assistants are paid through a Fiscal Intermediary, which is an entity that has a subcontract with us to provide wage and benefit processing and other fiscal intermediary responsibilities.

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 the designated representative, if you have appointed one, and your spouse, A parent can be your aide if you are 21 years of age or older. *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 but shall not be limited to routine dentistry provided by a Dentist. Preventative services, routine exams, as well as oral surgery, dental implants 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 consistent with Medicaid guidelines your physician explains in writing the circumstances that necessitate replacement of the denture.

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

DURABLE MEDICAL EQUIPMENT [DME] & SUPPLIES

Definition: Durable Medical Equipment [DME], includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula limited to gastrogastric, jejunostomy, or gastrostomy tube feeding or treatment of an inborn error of metabolism, and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, 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.

PROSTHETICS AND ORTHOTICS

Definition: Prosthetic appliances and devices are items which replace any missing part of the body.

Orthotic appliances and devices are used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.

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

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

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

HOME CARE SERVICES

PERSONAL CARE AIDE SERVICES

Definition: Personal Care Aide [PCA] means some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal Care must be medically necessary, ordered by the Enrollee's physician and provided by a qualified person as defined in 10 NYCRR 700.2[b][14], in accordance with a plan of care.

PCA Services may include assistance with the following [level I]:

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

PCA Services must include assistance with any combination of the following [level II]:

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

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

Home Health Aide

Definition: Home health aide [HHA] means a person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home. Qualifications of home health aides are defined in 10 NYCRR 700.2 [b][9].

In addition to any of the services provided by a PCA, an HHA can perform the following:

- Preparation of meals in accordance with modified diets or *complex* modified diets;
- Administration of medications;
- Provision of special skin care;
- Use of medical equipment, supplies and devices;
- Change of dressing to stable surface wounds;
- Performance of simple measurements and tests to routinely monitor the Member's medical condition;
- Performance of a maintenance exercise program; and
- Care of an ostomy after the ostomy has achieved its normal function;

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 aide 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.* There is a limit of 20 visits per calendar year in a setting other than the home, except for children under 21 and the developmentally disabled. Plan may determine that additional visits are needed.

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 or to maintain your current condition or prevent or slow your decline or deterioration. Examination, diagnosis, and treatment services are covered.

Coverage: Determined based on medical necessity.

Limitations: *Prior authorization is required.* There is a limit of 40 visits per calendar year in a setting other than the home, except for children under 21 and the developmentally disabled. Plan may determine that additional visits are needed.

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.* There is a limit of 20 visits per calendar year in a setting other than the home, except for children under 21 and the developmentally disabled. Plan may determine that additional visits are needed.

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 AND CONGREGATE MEALS

Definition: Home delivered meals are meals 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 and does not have assistance from an aide to prepare meals. They can also be used when a member is not eating healthy meals.

Definition: Congregate meals are meals provided to Members who participate in a Social Day Care program. [See Social Day Care on page 27]

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: means transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for Your condition for You to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. We use only approved Medicaid ambulette vendors to provide ambulette transportation services to you. 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 in a stay in nursing home 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: The Plan benefit is limited to three [3] months once you are designated as long term nursing home stay. After that, NYS regular Medicaid will cover you the service if you are eligible. *Prior authorization is required.*

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 including refraction are limited to 1 every 2 years.

Eye glasses do not require changing more frequently than every two years unless medically indicated, such as a change in correction greater than ½ diopter, or unless the glasses are lost, damaged, or destroyed and must be "Medicaid frames."

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 residing in a nursing home are not eligible for PERS.

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: medically necessary services provided to you by a properly licensed registered professional or licensed practical nurse. Private duty nursing services may be continuous and may go beyond the scope of care available from a certified home health agency [CHHA] and therefore can be provided by a Licensed Home Care Services Agency [LHCSA].

Coverage: Determined based on medical necessity, and consistent with Medicaid guidelines, when a Certified Home Health Agency [CHHA] is not available to provide the

services due the Enrollee's need for either continuous care or intermittent nursing services.

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 congregate meals 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.

TELEHEALTH

Definition: Telehealth means the use of electronic information and communication technologies by telehealth providers to deliver health care services delivered using electronic information and communication technologies, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self– management of an Enrollee.

Limitation: Telehealth shall not include delivery of health care services by means of audio–only telephone communication, facsimile machines, or electronic messaging alone, though use of these technologies is not precluded if used in conjunction with telemedicine, store and forward technology, or remote patient monitoring.

Coverage: Health care services that would be covered by the plan as part of the benefit package are now covered if delivered by telehealth. The following providers can provider telehealth services: physician, physician assistant, dentist, nurse practitioner, registered professional nurse [only when such nurse is receiving patient–specific health information or medical data at a distant site by means of remote patient monitoring], podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation.

You, your family/caregiver, Physician, and EverCare Choice, are all partners in the success of your care. You, your family/caregiver, and Provider[s] may receive a 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 is 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.

When you join EverCare, you will be on the New Member Team. After 90 days, your team is identified by the county you live in.

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 by the county you live in 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 monthly 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
- Assisting you with the social determinants of health such as food and housing resources
- 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, an EverCare Assessment Nurse will perform an initial assessment in your home. They will leave a proposed service plan that outlines the covered services you would benefit from based on the initial home visit and UAS–NY Community Assessment. This proposed service plan is reviewed with your primary Care Manager and the Assessment Nurse who did the initial assessment in your home. 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, your physician, and others involved in your care to develop a Person–Centered Service Plan that meets your needs. It is important that you take an active role in developing your plan. Your personal preferences are important. 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.

Once your Person–Centered Service Plan is finalized, you will receive a copy in the mail. The Person–Centered Service Plan that is mailed to you replaces the initial proposed service plan that the Assessment Nurse first left with you.

At least once every 6 months, an Assessment Nurse will come to your home for reassessment and to review your Person–Centered Service Plan to make sure that services you are receiving are clinically appropriate and are meeting your needs. You, or your designated representative, will be involved in this review.

REQUESTING CHANGES TO YOUR SERVICE PLAN

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.

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. We will make a decision within three [3] business days of getting all of the information, but in no more than fourteen [14] days after we received your Service Authorization 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].

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.

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

We must make a Service Authorization Determination and notify you of the determination by phone and in writing as fast as your condition requires and no more than:

a. Expedited: Seventy–two [72] hours of receipt of the Service Authorization Request
b. Standard: Fourteen [14] days of receipt of the Service Authorization Request
c. In the case of a request for Medicaid covered home health care services following an inpatient admission, one [1] business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy–two [72] hours after receipt of necessary information; but in any event, no more than three [3] business days after receipt of the Service Authorization Request.

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]. An extension of up to fourteen [14] calendar days may be requested by the Enrollee or provider on the Enrollee's behalf [written or verbal]. The plan also may initiate an extension of up to fourteen [14] calendar days if the extension is in the Enrollee's interest.

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 seventy–two [72] hours after we receive the Service Authorization request. The decision may take longer if EverCare Choice needs more information.

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

Your provider can request a *retrospective review*. A retrospective review means a review of documentation to determine if the services provided were medically necessary.

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

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.

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. If you disagree with our decision, you can Appeal the determination. You have sixty [60] days from the date on the letter sent to you to Appeal the decision. However, if you want to keep the services the same until we have a determination on the Appeal, then you must Appeal within ten [10] days from the date on the letter sent to you or by the date the decision takes effect, whichever is later.

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
- Provide the date by which you must Appeal to keep the services the same until the Appeal determination is made.
- If you want to Appeal but you don't want to keep the services the same or it is a new service then you have sixty [60] days from the date on the letter sent to you to request an Appeal.
- 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
- You will be provided with the case file which includes the medical records and other documents used to make the original decision.

  Once the Appeal is decided, then we will send you a decision in a letter called a Final Adverse Determination. Your appeal will be decided within thirty [30] days from the day we receive an appeal [The review period can be increased up to fourteen [14] days if you request an extension or we need more information and the delay is in your interest.]. If your health is at risk then we will fast track your appeal and decide it in 72 hours. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. [The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.]

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

  If you disagree with our appeal decision in the Final Adverse Determination notice, then you have a right to a State Fair Hearing.

The notice will also tell you about your right to a State 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 the same until your Fair Hearing is decided, you must request a Fair Hearing within ten [10] calendar days of the date of the appeal decision or by the date the appeal decision takes effect, whichever is later.
- If you want a State Fair Hearing, but you don't want your services the same or it is a new service then you have one hundred and twenty [120] days from the date on the notice about our decision on your appeal.
- You will be provided with the evidentiary packet that the Final Adverse Determination was based upon

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

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]
- Mammogram

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:

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to receive information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to receive information in a language you understand; you can get oral translation services free of charge.
- You have the Right to receive information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and due consideration for your dignity.
- You have the Right to request and receive a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to sex, [including gender identity and status of being transgender], race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out–of–network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate. The New York State Department of Health complaint line is 1-866-712-7197.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to 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
- Tell the Plan when you are Hospitalized
- 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.

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.

INVOLUNTARY DISENROLLMENT

EverCare Choice is required to initiate disenrollment of you within five [5] business days from the assessment making such determination that:

- You were assessed and no longer demonstrate a functional or clinical need for the authorization and delivery of any community–based long term care services on a monthly basis or, for non–dual eligible, in addition, You no longer meet the nursing home level of care as determined using the assessment tool prescribed by the State of New York – currently the UAS
- You no longer require and receive at least one community based long term care service in each calendar month

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

- You only receive Social Day Care services from the MLTC plan
- You no longer live in Dutchess, Orange, or Rockland County
- You have been away from the coverage area 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 OASAS 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 require nursing home care of more than three [3] months after being designated as long term nursing home stay
- You provide us with false information, otherwise deceive us, or engage in fraudulent conduct with respect to any substantive aspect of your plan membership. 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
- 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

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. The effective date of disenrollment shall be the first day of the month following the month in which the event occurred that resulted in You becoming ineligible for continued enrollment.

SECTION VI | Plan Policies & Procedures

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 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!

We will try our best to address your concerns or issues as quickly as possible and to your satisfaction. You may use either our complaint process or our appeal process, depending on what kind of concern[s] you are experiencing.

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

To file a complaint or to appeal a plan action, please call: 845–569–0500 or writing to EverCare Choice, 31 Cerone Place Newburgh, NY 12550. When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

PARTICIPANT OMBUDSMAN

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of

New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like [Insert Plan Name]. This support includes unbiased health plan choice counseling and general plan related information. Contact ICAN to learn more about their services:

Phone: 1-844-614-8800 (TTY Relay Service: 711) Web: www.icannys.org | Email: ican@cssny.org

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information but the process will be completed within 7 days of receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 30 days of receipt of necessary information, but the process must be completed within 44 days of the receipt of the complaint.

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

How do I Appeal a Complaint Decision?

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

For standard appeals, we will make the appeal decision within 30 business days after we receive all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited complaint appeal process. For expedited complaint appeals, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and expedited complaint appeals,

we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

What is an Action?

When 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 terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. [See How do I File an Appeal of an Action? below for more information.]

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

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

If we are restricting, reducing, suspending or terminating an authorized service, the notice will also tell you about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan

sends you a letter about an action it is taking [like denying or limiting services, or not paying for services], you must file your appeal request within 60 days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached by calling 877–255–3678 or writing to EverCare Choice, Attention: Appeals, 31 Cerone Place Newburgh, NY 12550. The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

Your services will continue until you withdraw the appeal, or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. [See Fair Hearing Section below]

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

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

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

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

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

Expedited Appeal Process

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

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

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

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

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

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

State Fair Hearings

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

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

the intended effective date of our action to restrict, reduce, suspend or terminate your services, whichever occurs later.

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

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

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

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

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

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

- Fax a Printable Request Form: [518] 473–6735
- Request by Telephone:

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

- Request in Person:

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

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

State External Appeals

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

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

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

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

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

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