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Welcome to Hamaspik CHOICE

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

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

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

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

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

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

This handbook is intended to serve as a reference for you, so please save it. In includes information about your Managed Long Term Care services, and important rules for working with Hamaspik CHOICE.

This handbook is available in other languages. For members who require it, we provide a language interpretation service for no cost to you, which may be utilized to orally translate materials to you over the phone. For members with visual impairments, Hamaspik Choice staff members are available to read this member handbook.

We are always happy to answer any questions or comments you may have. Our toll-free telephone number is: **855-552-4642** (855-55-CHOICE), TTY users, please call 711.

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

58 Route 59, Suite 1
Monsey, NY 10952

Benefits of Joining Hamaspik CHOICE

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

Hamaspik CHOICE will provide health education to Enrollees on an on-going basis through methods such as conversations with your care manager, posting information on the Hamaspik CHOICE web site at www.hamaspikchoice.org, or upon Enrollee request based on your individual concerns. We can help you with many preventive health and public health topics, such as:

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

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

Hamaspik CHOICE's staff has extensive experience in planning and providing services for individuals with long term disabilities and various medical conditions, including conditions that require specialized knowledge, equipment and accommodations. As a Hamaspik CHOICE member, you will have a Person Centered Services Plan (or "PCSP") that includes information about your health needs, goals and services. Your PCSP is a written plan of the services you need, how often you need them, and for how long. It includes services covered by Hamaspik CHOICE that are medically necessary and non-covered services. Your PCSP is based on our assessment of your health, your long term care needs, your personal preferences, and the orders and recommendations of your physician(s). Your PCSP is reviewed with you and with your physician as needed, at least every six months and more often if your health status changes. As your needs change, your PCSP will change to meet those needs.

We will work with your physician to coordinate your care.

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

The sections in this Member Handbook provide more information about all of these topics, and more. Please review the Member Handbook to understand how Hamaspik CHOICE works with you to meet your needs. If you have any questions about the information in this Member Handbook, please talk to your care manager, or our Member Services staff. Our toll-free telephone number is:

855-552-4642 (855-55-CHOICE)

TTY users, please call 711

Eligibility and Effective Dates of Coverage

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

1. Age requirements:
   - Dual eligible, age 21 and older must enroll in a plan in order to receive community-based long term care services that are covered by Medicaid (also known as “CBLTC services”)
   - The following individuals may voluntarily enroll in a Plan
     - ✓ Dual eligible individuals age 18-20
     - ✓ Non-dual eligible individuals, age 18 and older

2. Reside in Dutchess, Orange, Putnam, Rockland, Sullivan or Ulster County

3. Be Eligible for Medicaid as determined by your Local Department of Social Services

4. Be capable, at the time of enrollment, of returning to or remaining in your home, community or nursing home without jeopardy to your health and safety

5. Be in need of long term care services for a continuous period of more than 120 days from the date of enrollment. Long term care services include: Nursing services, rehabilitation therapies, home health aide or personal care services, adult day health care, private duty nursing or Consumer-Directed Personal Assistance Services (also known as “CDPAS”).

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

Enrollment or denial of enrollment in our program must be approved by your Local Department of Social Services (LDSS) or New York Medicaid Choice.

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

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

Hamaspik CHOICE does not unlawfully discriminate in enrollment or the 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, or place or origin.

Assessment Process

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

- Anyone may contact us – you, your family, a friend, a medical provider – to notify us of your interest in Hamaspik CHOICE. When we are informed that you are interested in learning more about the program, a Hamaspik CHOICE staff member will contact you to explain our program.

- All individuals who are referred to Managed Long Term Care for the first time must complete an eligibility determination by the New York State Conflict Free Evaluation and Enrollment Center (CFEEC), as the first step in the enrollment process. A CFEEC nurse will complete an evaluation at your home (or hospital or nursing home) to determine if you need community-based long term care services. You can contact CFEEC at 855-222-8350. (TTY users, call 888-329-1546.) If you need assistance, our enrollment staff can help connect you to the CFEEC program.
    - ✓ Note: This step does not apply to individuals transferring from another MLTC plan or individuals already receiving Community-based Long Term Care services through another Medicaid program.

- If you are interested and are eligible for benefits under Medicaid, Hamaspik CHOICE will then conduct an initial assessment for MLTC eligibility. This will be done at a time that is convenient to you, and will take place within thirty days of the first contact to the plan requesting enrollment. The assessment will be performed by a Registered Nurse in your home or Nursing Home.

- Together with your input, a Person Centered Service Plan (or "PCSP") will be designed, in order to meet your health care needs.

- Your Care Manager may contact your physician to discuss your PCSP if necessary. If you want us to discuss your PCSP with other individuals who are involved in your care, please let us know.

Enrollment

During the assessment visit, the Nurse will explain more about Hamaspik CHOICE and will provide you with written information about the program. If you decide to join Hamaspik CHOICE, you will sign an Enrollment Agreement. During the enrollment process, we will explain how to access services and give you a list of Hamaspik CHOICE network providers.

Your enrollment must be approved by New York Medicaid Choice, LDSS or other entity as designated by the NYS DOH.

After you enroll, you will receive a Hamaspik CHOICE member identification card. Remember to keep your regular Medicaid, Medicare and third party insurance cards, too. You will need to use these cards for services not covered by Hamaspik CHOICE that may be covered by these other insurance programs.

Effective Dates of Enrollment

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

Continuity of Care

If you are transitioning from a Medicaid community based long-term program, you will continue to receive services under your pre-existing service plan for at least 90 days after enrollment. Your services will be authorized at the same level, scope and amount as you received through Medicaid.

If you enroll in Hamaspik CHOICE because your former MLTC Plan closed, or reduced its service area, or merged with another MLTC Plan, you have the right to keep your previous Person Center Service Plan for up to 120 days after enrollment. Your services will be authorized at the same level, scope and amount as you received through your former MLTC Plan.

During the 90-day or 120-day transition period (depending on the circum-stances described above), Hamaspik CHOICE will complete an assessment of your needs. If Hamaspik Choice then decides to change the services authorized, you will receive a notice of action, which articulates your right to file an appeal. You will have the right to continue receiving the same services when you request an appeal or fair hearing.

Requirements if You Want to Transfer to Another MLTC Plan

As a new Hamaspik Choice member, you can try us for 90 days. You may leave Hamaspik 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 Hamaspik Choice for none 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's Department of Social Services or the New York State Department of Health all agree that leaving Hamaspik 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 a Program 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. Hamaspik Choice will provide the care that 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 would 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 Hamaspik Choice.

Service Benefit Package

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

Care Management is provided directly through Hamaspik Choice. The following services are provided through contracted providers that have agreed to work with Hamaspik CHOICE:

- Adult Day Health Care
- Audiology and Hearing Aids
- Consumer Directed Personal Assistances Services
- Dentistry
- Durable Medical Equipment
- Home Care (including nursing, home health aide, physical therapy, occupational therapy, speech pathology, and medical social services)
- Home Delivered meals and Congregate meals
- Non-emergency medical transportation
- Nursing Home Care
- Nutrition
- Optometry and Eyeglasses
- Personal Care
- Personal Emergency Response System
- Podiatry
- Rehabilitation Therapies (Physical Therapy, Occupational, Therapy, Speech Therapy or other therapies that are provided in a setting other than your home.)
- Respiratory Therapy
- Private Duty Nursing
- Social Adult Day Care
- Social and Environmental Supports

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

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

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

More about the services and benefits of Hamaspik CHOICE

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

Care Management: Care management services are provided to all members enrolled in Hamaspik CHOICE. Care Management is a process that assists you in accessing necessary services as identified in your PCSP. It also provides referral and coordination of other services in support of the PCSP. Care management services will assist you in obtaining needed medical, social, educational, psychosocial, financial and other services in support of the PCSP irrespective of whether the needed services are covered under Hamaspik CHOICE. (See page 22 for more information.)

Consumer Directed Personal Assistance Services (CDPAS): The provision of some or total assistance with personal care services, home health aide services, and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision, and direction of the Member or the Member's designated representative. Personal assistants are paid through a Fiscal Intermediary, which is a company that has a contract with Hamaspik Choice to manage the wages and benefits for these workers.

To participate in the consumer directed personal assistance services, you must meet the following eligibility requirements:

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

When you enroll in Hamaspik CHOICE, and during each re-assessment, we will talk with you about CDPAS as a voluntary health benefit that is available in your MLTC plan. Any restriction, reduction, suspension, or termination of authorized CDPAS services, or denial of a request to change CDPAS, is considered an adverse determination. You may file an appeal as described in this Member Handbook, and you may request a fair hearing or external appeal upon a Final Determination.

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

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

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

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

This category of services also includes: Medical and Surgical Supplies, Hearing Aid Batteries, Prosthetics, Orthotics, Orthopedic Footwear, Respiratory therapy including oxygen, and Nutritional Supplements.

- **Medical and Surgical Supplies:** Hamaspik CHOICE will coordinate with your health care professionals on required medical and surgical supplies. These are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear that have been ordered by a practitioner in the treatment of a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value

- **Oxygen and Respiratory Therapy:** Hamaspik CHOICE will ensure that these services are provided by a qualified respiratory therapist.

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

- **Enteral Formula and Nutritional Supplements:** Based on Medicaid guidelines, coverage of enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and only in the following three conditions:
  (1) individuals who are fed via nasogastric, jejunostomy, or gastrostomy tube; and
  (2) individuals with rare inborn metabolic disorders.

  Coverage for individuals with certain inherited diseases of amino acid and organic acid metabolism shall include modified solid food products that are low protein or which contain modified protein.

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

- With the help of your care manager, you may choose a provider in your area that is contracted with Hamaspik CHOICE to provide services to

you

- When making appointments, be sure to inform the office that Hamaspik CHOICE is your managed long term care plan (MLTCP)
- You are eligible for one eye exam and one pair of eyeglasses every two years
- Bring your Hamaspik CHOICE ID card to all appointments
- You should never be asked to pay out of pocket for any costs associated with your care. Please let your nurse care manager know if you are ever asked to make payments to a provider. Your costs will be fully covered by Hamaspik CHOICE.

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

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

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

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

Non-Emergency Medical Transportation. Hamaspik CHOICE will arrange and pay for your non-emergency transportation services, in order to receive necessary medical care that is reimbursed by Hamaspik CHOICE, Medicaid, or Medicare. Services will be provided by car service, ambulette, or

ambulance, depending on your needs. If you need transportation by ambulette or ambulance, Hamaspik CHOICE will only use approved Medicaid providers.

Please follow these important instructions for requesting transportation:

- Transportation provided by Hamaspik CHOICE is for non-emergency medical appointments. If you are ill and need to go to the hospital or emergency room right away, please call 911 immediately.
- All requests for transportation must be made at least 2 business days in advance
- When calling to request transportation, kindly have the doctor's name, specialty and phone number available. We will need this information to schedule your trip.
- Confirmation of appointment will be made by our member services department by calling the service location to verify your appointment.
- Please call our transportation department as soon as possible, if there are any changes made to your appointment time/date
- We try to accommodate requests for specific transportation vendors; accommodation is always based on vendor availability
- If you need to see a specialist out of county, your local PCP will need to complete an *Out of County Form* that explains the reason for why it is necessary for you to travel out of county for your services. Requests for out of county trips should be made at least 10 days in advance.
- To schedule your trip, please call during business hours Monday through Friday, 9:00 AM-5:00 PM
- You can also schedule your transportation online on our website www.hamaspikchoice.org

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

- Note: Nursing Home Care is covered for individuals who are considered a

permanent placement for at least three months. Following that time period, your nursing Home Care may be covered through regular Medicaid.

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

Personal Care: Hamaspik CHOICE will coordinate the provision of personal care and help you with such activities as bathing, personal hygiene, dressing, preparing meals and eating, and other in-home support, as determined by an assessment of your needs.

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

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

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

Podiatry/ Foot Care: Foot care is provided by licensed podiatrists listed in the Hamaspik CHOICE Provider Network. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet may be covered if deemed necessary by Hamaspik CHOICE's clinical department. No prior approval or authorization is necessary for podiatry consultation once per year for those members whose condition requires it.

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

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

Telehealth: Telehealth delivered services use electronic information and communication technologies by telehealth providers to deliver health care services, which include the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of an Enrollee. Telehealth provider means: physician, physician assistant, dentist, nurse practitioner, registered professional nurse (only when such nurse is receiving patient-specific health information or medical data at a distant site by means of remote patient monitoring), podiatrist, optometrist, psychologist, social worker, speech language pathologist, audiologist, midwife, certified diabetes educator, certified asthma educator, certified genetic counselor, hospital, home care agency, hospice, or any other provider determined by the Commissioner of Health pursuant to regulation.

- Note: Telehealth does not include the delivery of services by audio-only communication by telephone, fax machines, or electronic messaging alone, though the use of these technologies may be included as part of other telemedicine or remote patient monitoring.

Paying Providers for Covered Services

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

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

Accessing Services

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

Hamaspik CHOICE requests that you notify us of any non-covered service you are receiving within two business days of receiving the service, so that it can be included in your PCSP. If we are notified at least 48 hours in advance, we can arrange appropriate transportation to and from the service provider and ensure seamless delivery of services. If you are hospitalized, it is important for you to let us know, because we can coordinate your discharge plan and ensure that you receive the services that you need when you come home.

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

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

If you are unhappy with a provider's service delivery or access to service, you may use the internal grievance and appeals process outlined in the section titled Member Grievance and Appeal Process. (See page 32.)

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

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

Urgent Care

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

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

Emergency Care

Emergency Services refers to medically necessary services required to evaluate and stabilize an emergency medical condition. An emergency condition means that you have a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect that the absence of immediate medical attention could: (1) result in placing your health in serious jeopardy, or, in the case of a behavioral condition, place the health of you or others in serious jeopardy; (2) seriously impair your bodily functions; (3) result in serious dysfunction of any body organ or part of you; or (4) seriously disfigure you.

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

If you are hospitalized, it is important that you, a family member or a friend call your Hamaspik CHOICE care manager or call Hamaspik CHOICE as soon as possible. (Please call us at: 1-855-55-CHOICE.) Our staff will re-arrange any scheduled services you might miss during this time, and your care manager will begin making any necessary changes to your PCSP. When you are discharged from the hospital, we will help you avoid any unnecessary gaps in the services you need. Your care manager will also review your PCSP, and will authorize any new services that may be required upon discharge.

Getting Help During Non-Business Hours

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

Services Outside the Service Area

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

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

Medicaid Services Not Covered by Our Plan

There are some Medicaid services that Hamaspik CHOICE does not cover, but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 855-552-4642, if you have a question about whether a benefit is covered by Hamaspik CHOICE or Medicaid. Your care manager can also coordinate these non-covered services for you.

Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy. Most prescription and non-prescription drugs, as well as compounded prescriptions are covered by regular Medicaid or Medicare Part D if you have Medicare.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare

- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services including:

- Methadone Treatment
- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Conversion or Reparative Therapy
- Family Planning

Services Not Covered by Hamaspik CHOICE or Medicaid

You must pay for services that are not covered by Hamaspik CHOICE or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by Hamaspik CHOICE or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services from a Provider that is not part of the plan
  (unless Hamaspik CHOICE sends you to that provider)

If you have any questions, call Member Services at 855-552-4642.

Selecting Providers

For covered services, Hamaspik CHOICE has a network of providers who provide high quality care and are committed to the Hamaspik CHOICE mission of helping you to be as independent as possible. A list of Hamaspik CHOICE providers is given to you upon initial assessment and is mailed annually. The Hamaspik CHOICE Provider Directory is posted on the Hamaspik CHOICE website, www.hamaspikchoice.org. The Provider Directory is updated with all new providers on a monthly basis. Additionally, an updated Provider Directory can be mailed to you, upon your request to your care manager.

If you wish to change providers, call your care manager, who will help you identify another provider in our network. We want you to be satisfied with the services you receive. If there are other providers that you would like to have us include in our network, please let us know and we will explore this option.

Hamaspik CHOICE strives to build and maintain a provider network that can deliver services in a culturally competent manner. Our provider network includes organizations and people who are able to work with members who do not speak English, and who come from diverse cultural and ethnic backgrounds, and religious faiths. If Hamaspik CHOICE does not have a provider in its network with the training and expertise to meet a specialized health care need included in your PCSP, we will approve services from a provider outside of our network.

If a network provider that you are using is no longer going to be in the network, we will let you know immediately and will assist you in choosing another provider from our network. If you are in the middle of a course of treatment, you may continue with the provider for a period of up to 90 days. If you are a new member, you may continue an ongoing course of treatment with an out-of-network provider for an interim period of up to 60 days. In either case, Hamaspik CHOICE permission is required and is dependent upon the provider's willingness to accept payment from Hamaspik CHOICE, and to comply with our policies and procedures.

If you need a Medicare services, you have the freedom to choose providers for these services. However, when Medicare stops paying for these services, you must use a network provider in order for Hamaspik CHOICE to continue to cover the service. Services not covered by Hamaspik CHOICE will continue to be covered by Medicare and/or Medicaid fee-for-service. It is important to carry with you your plan benefit card, Medicare and Medicaid cards.

Care Management

Hamaspik CHOICE's care management program ensures that your services are provided in a way that is designed meet your individual needs and is appropriately coordinated. Care management means a process that assists you with accessing necessary covered services as identified in the Person Centered Service Plan (PCSP), described on the next page. Care management services include referral, assistance in or coordination of services for you, and monitoring your services to be sure they are effective in meeting your needs.

Care management focuses on your medical, social, educational, psychosocial, financial and other services in support of the PCSP, irrespective of whether the needed services are included in the Benefit Package. Care management includes people, an automated information system, and operational policies and procedures that have been established to meet the requirements of State and Federal regulations, and our program has been approved by the Department of Health.

Hamaspik CHOICE Care Managers include staff who represent a range of backgrounds and have relevant degrees as necessary to meet your needs. Our staff are excited to work with members who do not speak English, and who come from diverse cultural and ethnic backgrounds, and religious faiths. If you are ever unhappy with your care manager, you may ask for a change, and we will make every attempt to accommodate your request.

The care management program includes the following components:

- Provides you with a minimum of one care management telephone contact per month
- Provides you with a minimum of one care management home visit every six (6) months
- Ensures that the level and degree of care management, and your Person Centered Service Plan (PCSP) address your needs and are based upon the acuity and severity of your physical and mental conditions;
- Monitors your plan of care to be sure you are getting the services that are included, and to be sure that the services are meeting your needs;
- Educates you, as applicable, about Consumer Directed Personal Assistance Services
- Educates you on service options when creating the Plan of Care with

you after the initial assessment and reassessment visits;

- Has a maximum two business day response time to enrollee/member contacts.
- You can access Hamaspik CHOICE care management staff, 24 hours a day, 7 days a week, and 365 days a year by calling (855) 552-4642 at any time, for information or emergency consultation services.

Person Centered Service Plan (PCSP)

Person centered service planning is an important part of care management. Each Hamaspik CHOICE member has an individual Person Centered Service Plan, which is your written care plan that outlines your health and long term care needs and goals and includes all services authorized to meet your needs. Person centered service planning includes consideration of your current and unique psychosocial and medical needs and history, as well as your functional level and support systems.

When developing your PCSP, your care manager will speak with you about your goals and your needs, as well as your preferences for how you want to receive your services. Your care manager may also talk with your family or other caregivers, and your doctor when developing your PCSP. If there are specific people who you want your care manager to consult with, please let him/her know. Your care plan will be developed within fifteen (15) days of enrollment or each re-assessment. Your care manager will ask you to sign your care plan, and you will receive a copy for your records.

Service Authorizations

Your PCSP is the basis for the services that are authorized for you. We will cover services that are medically necessary. This means services that you need in order prevent, diagnose, correct or cure conditions that can cause acute suffering or pain, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap.

If you would like to receive a new, covered service not included in your current PCSP, or would like to change the amount, frequency or duration of a covered service you are currently receiving, prior approval is required. A prior authorization is required when you request either a new service or a change in service for a new authorization period. A concurrent review is required when you request more of the same service than is currently authorized by your PCSP.

You may also request an expedited review, which means you will get a fast response to your request. However, the determination about whether the review will be expedited depends on whether Hamaspik CHOICE or your provider determines that a delay could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

For prior authorizations, expedited reviews are handled within seventy-two (72) hours of your request. Standard reviews are handled within 3 business days of receipt of necessary information, but no more than 14 days from when we receive your request.

For Concurrent Reviews, expedited reviews are handled within 1 business day of our receipt of necessary information, but no more than seventy-two (72) hours after we received your request. Standard reviews are handled within 3 business days after receipt of necessary information, but no more than 14 days after receipt of request.

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

The review periods can be increased up to 14 days if you or your provider requests it or if we need more information and the delay is in your interest. If you do not agree with the extension, you can file a complaint with Hamaspik CHOICE or with DOH.

If you are not satisfied with the decision we make, you can appeal it. Please see the section on Appeals in this Member Handbook for more information.

Termination of Coverage

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

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

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

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

Involuntary Disenrollment

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

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

- You clinically require nursing home care but are not eligible for nursing home care under Medicaid Institutional rules.
- You are no longer eligible to receive Medicaid benefits.
- An enrollee whose sole service is identified as Social Day Care must be assessed and recommended for disenrollment from the MLTC plan within five business days of the assessment making such determination.
- You are assessed as no longer demonstrating a functional or clinical need for community based long term care services. In addition, for non-dual eligible members (people without Medicare benefits), you must disenroll if you no longer meet the nursing home level of care as determined using the assessment tool prescribed by the Department of Health.
- You no longer need or receive long term care services in each calendar month. These services include: nursing services, rehabilitation therapies, home health aide or personal care services, adult day health care, private duty nursing and/or Consumer Directed Personal Assistance Services (CDPAS).
- You are incarcerated. The effective date of disenrollment shall be the first day of the month following incarceration.
- You provide Hamaspik CHOICE with false information, otherwise deceive us, or engage in fraudulent conduct in relation to your Hamaspik CHOICE membership.

Hamaspik CHOICE may also disenroll you if either of the following applies:

- You, your family or others in your immediate environment engage in behavior that jeopardizes your health or safety or the safety of others.
- You fail to pay or fail to make satisfactory arrangements to pay the spend-down/surplus amount due to Hamaspik CHOICE after a thirty-day grace period.

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

Medicaid Spend-Down

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

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

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

If you have a spend down, that amount must be paid by the first of each month starting with the month of enrollment. Please make your payment payable to the order of Hamaspik CHOICE, Inc. and send it to:

58 Route 59, Suite #1
Monsey, NY 10952

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

Veterans Protections

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

Cultural and Linguistic Competency

Hamaspik 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.

Rights and Responsibilities

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

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

- Appoint someone to speak for you on your behalf about your care and treatment;

- Seek assistance from the Participant Ombudsman program.

- Make Advance Directives and plans regarding your care. (See page 51 for details on Advance Directives.)

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

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

- Receive covered services through Hamaspik CHOICE;

- Use the Hamaspik CHOICE network providers for covered services;

- Obtain prior authorization for covered services, except for pre-approved services. Refer to specific service in the Service Benefit Package section of this handbook to find out if a specific service requires prior approval;

- Be seen by your physician if a change in your health status occurs;

- Share complete and accurate health information with your health care providers;

- Inform Hamaspik CHOICE staff of any change in your health, and make it known if you do not understand or are unable to follow instructions;

- Follow your PCSP recommended by Hamaspik CHOICE staff;

- Cooperate with and be respectful to Hamaspik CHOICE staff and not discriminate against Hamaspik CHOICE's staff on the basis of race, color, national origin, mental or physical ability (other than mandated physical eligibility for the program), religion, age, sex, sexual orientation or marital status;
- Notify Hamaspik CHOICE within 2 business days before receiving either non-covered services or pre-approved covered services. We prefer that you notify us before receipt of services, but no later than 2 days after receipt.

- Notify Hamaspik CHOICE in advance whenever you will not be home to receive service or care that has been arranged for you;

- Inform Hamaspik CHOICE before permanently moving out of the service area or of any absence from the service area;
- Take responsibility for your actions if you refuse treatment or do not follow Hamaspik CHOICE instructions; and
- Pay your financial obligations, if any.

Member Complaint and Appeal Process

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

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

To file a complaint or to appeal a plan action, please call: 855-552- 4642.
Or write to: Hamaspik CHOICE, 58 Route 59 Suite 1, Monsey, NY 10952.

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

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process will be completed within 7 days of receipt of the complaint.

2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

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

How do I Appeal a Complaint Decision?

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

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

What is an Action?

When Hamaspik Choice 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 our decision on appeal.

The notice will also tell you about your right to an appeal and a State Fair Hearing. The notice will:

- Explain the difference between an appeal and a Fair Hearing;
- It will say that you must file an appeal before asking for a Fair Hearing; and
- It will explain how to ask for an 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. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 day of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I Contact my Plan to file an Appeal?

We can be reached by calling: 855-552-4642. Or you may send your appeal in writing to:

Hamaspik CHOICE
58 Route 59, Suite #1
Monsey, NY 10952.

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and include a copy of your case file which includes medical records and other documents used to make the original decision. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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

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

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

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

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

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

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

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

Expedited Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. 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 to:

  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 (ask the operator to call 1 (877) 502-6155)

- Request in Person:

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

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

State External Appeals

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

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

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

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

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

SERVICE AUTHORIZATIONS & ACTION REQUIREMENTS

Definitions

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

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

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

General Provisions

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

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

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

Timeframes for Service Authorization Determination and Notification

1. For Prior Authorization requests, the MLTC Plan must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

    a. Expedited: Seventy-two (72) hours after receipt of the Service Authorization Request
    b. Standard: Fourteen (14) days after receipt of request for Service Authorization Request.

2. For Concurrent Review Requests, the MLTC Plan must make a Service Authorization Determination and notice the Enrollee of the determination by phone and in writing as fast as the Enrollee's condition requires and no more than:

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

3. Up to 14 calendar day extension is permitted in some cases. An extension may be requested by Enrollee or provider on Enrollee's behalf (written or verbal). The plan also may initiate an extension if it can justify need for additional information and if the extension is in the Enrollee's interest. In all cases, the extension reason must be well documented.

    The MLTC Plan must notify enrollee of a plan-initiated extension of the deadline for review of his or her service request. The MLTC Plan must explain the reason for the delay, and how the delay is in the best interest of the Enrollee. The MLTC Plan should request any additional information required to help make a determination or redetermination, and will help the enrollee by listing potential sources of the requested information.

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

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

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

Other Timeframes for Action Notices

When the MLTC Plan intends to restrict, reduce, suspend, or terminate a previously authorized service within an authorization period, whether as the result of a Service Authorization Determination or other Action, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, except when:

- the period of advance notice is shortened to five (5) days in cases of confirmed Enrollee fraud; or

- the MLTC Plan may mail notice not later than date of the Action for the following:
    - the death of the Enrollee;
    - a signed written statement from the Enrollee requesting service termination or giving information requiring termination or reduction of services (where the Enrollee understands that this must be the result of supplying the information);
    - the Enrollee's admission to an institution where the Enrollee
    - is ineligible for further services;
    - the Enrollee's address is unknown and mail directed to the Enrollee is returned stating that there is no forwarding address;
    - the Enrollee has been accepted for Medicaid services by another jurisdiction; or the Enrollee's physician prescribes a change in the level of medical care.

For community-based long term care services (CBLTCS) or institutional long term care services (ILTCS), when the MLTC Plan intends to reduce, suspend or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, it must provide the Enrollee with a written notice at least ten (10) days prior to the effective date of the intended Action, regardless of the expiration date of the original authorization period, except under the circumstances described in 1(a) or (b) above.

For CBLTCS and ILTCS, when the MLTC Plan intends to reduce, suspend, or terminate a previously authorized service, or issue an authorization for a new period that is less in level or amount than previously authorized, the MLTC Plan will not set the effective date of the Action to fall on a non-business day, unless the MLTC Plan provides "live" telephone coverage available on a twenty-four (24) hour, seven (7) day a week basis to accept and respond to Complaints, Complaint

Appeals and Action Appeals.

The MLTC Plan must mail written notice to the Enrollee on the date of the Action when the Action is a denial of payment, in whole or in part,

When the MLTC Plan does not reach a determination within the Service Authorization Determination timeframes described in this Appendix, it is considered an Adverse Determination, and the MLTC Plan must send notice of Action to the Enrollee on the date the timeframes expire.

Contents of Action Notices

The MLTC Plan must utilize the model MLTC Initial Adverse Determination notice for all actions, except for actions based on an intent to restrict access to providers under the recipient restriction program. For actions based on an intent to restrict access to providers under the recipient restriction program, the action notice must contain the following as applicable:

- the date the restriction will begin;
- the effect and scope of the restriction;
- the reason for the restriction;
- the recipient's right to an appeal;
- instructions for requesting an appeal including the right to receive aid continuing if the request is made before the effective date of the intended action, or 10 days after the notices was sent, whichever is later;
- the right of MLTC Plan to designate a primary provider for recipient;
- the right of the recipient to select a primary provider within two weeks of the date of the notice of intent to restrict, if the MLTC Plan affords the recipient a limited choice of primary providers;
- the right of the recipient to request a change of primary provider every three months, or at an earlier time for good cause;
- the right to a conference with MLTC Plan to discuss the reason for and effect of the intended restriction;
- the right of the recipient to explain and present documentation, either at a conference or by submission, showing the medical necessity of any services cited as misused in the Recipient Information Packet;
- the name and telephone number of the person to contact to arrange a conference;
- the fact that a conference does not suspend the effective date listed on the notice of intent to restrict;
- the fact that the conference does not take the place of or abridge the recipient's right to a fair hearing;
- the right of the recipient to examine his/her case record; and

- the right of the recipient to examine records maintained by the MLTC Plan which can identify MA services paid for on behalf of the recipient. This information is generally referred to as “claim detail” or “recipient profile” information.

Participant Ombudsman Program

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

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

  ICAN’s Phone: 1-844-614-8800 TTY: 711

  Web: www.icannys.org

  Email: ican@cssny.org

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

Money Follows the Person (MFP)/Open Doors

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

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

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

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

For more information about MFP/Open Doors, or for assistance to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 844-545-7108. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

Your Hamaspik CHOICE Care Manager can also help you to set up a visit from a Transition Specialist or Peer. You can contact your Care Manager at 855-552-4642.

Advance Directives

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

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

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

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

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

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

- Deciding About Health Care – A Guide for Patients and Families
- Appointing Your Health Care Agent – New York State's Proxy Law
- Health Care Proxy form
- Medical Orders for life Sustaining Treatment form

Your Hamaspik CHOICE Care Manager will provide you with education regarding Advance Directives. Education will be provided upon initial assessment, upon re-assessment, and during your monthly phone contacts.

This includes:

- You will be educated on the benefits of executing advance directives.
- You will be notified of your rights in regards to advance directives
- You will be provided with documents to assist in this process.
- When setting up initial assessment visit and re-assessment visit, Hamaspik Choice will encourage you to have family present as it is beneficial to have family included in the discussion regarding Advance Directives.
- Health Care Proxy educational forms and MOLST forms will be distributed during the initial assessment visit.
- Upon re-assessment, the Nurse Assessor will re-educate and review your health Care Proxy educational forms and MOLST forms.
- You will be asked if you have executed an advance directive. The response will be noted in your member record. If you have advanced directives, you will be asked to provide a copy. The copy will be filed in your record.
- If you notify us that you have on file with your physician, your care manager will reach out to your physician to obtain a copy of these forms to have on file with Hamaspik CHOICE.
- Your Care Manager will coordinate with the physician that this be discussed at members next scheduled MD visit.
- If you express interest in advance directives at your initial or reassessment visit, your Care Manager will provide you with additional follow up on the forms with either a phone call or in home visit as requested. Follow up will include discussion with you and your family on importance of forms, and coordination with MD for forms completion.
- Hamaspik CHOICE will document and keep track of which members have been educated on Advance Directives, have expressed interest in Advance Directives, and have provided a copy of their Advance Directives. The reported information will afford Hamaspik Choice with ability to continue educating and providing guidance to its membership on the subject of advance directives.
- Hamaspik CHOICE may provide copies of the advance directive on file to designated health care professionals, upon your request.

Additional Information Available Upon Request

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

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

We Want Your Feedback

Each year, we will ask your opinion about the services you receive from our network providers and we will provide confidential feedback to providers to improve services. When you receive this survey, we hope you will participate. Your feedback is very important to us.

Definitions

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

Consumer Directed Personal Assistance Services ("CDPAS"): The provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of the Member or the Member's designated representative. Personal assistants are hired, trained, and (if necessary) fired by the Member or designated representative. Personal assistants are paid through a Fiscal Intermediary, which is a company that has a contract with Hamaspik CHOICE to manage the wages and benefits for these workers.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any of bodily organ or part of such person; or (d) serious disfigurement of such person.

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

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

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

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

Long Term Services and Supports ("LTSS"): Health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses, and who require assistance with routine daily activities, such as bathing, dressing, preparing meals, and administering medications. LTSS is comprised of several community-based services, such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Care Health Programs, Personal Care Services, and institutional services including Nursing Homes and Residential Health Care Facilities.

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

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

Money Follows the Person ("MFP"): A program that is part of Federal and State initiatives designed to change how long term care services are provided and to promote consumer choice. MFP is designed to streamline the process to move vulnerable people out of institutions for their care. Under the name Open Doors, the MFP program funds Transition Specialists and Peer Support to assist individuals to transition out of institutions (such as nursing homes and intermediate care facilities) and into qualified community settings. A qualified setting may be a house, an apartment, or a group home.

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

Non-Emergency Medical Transportation: Transport by taxi or livery service, ambulette, ambulance, or public transportation, at the appropriate leve for the Member's condition, for the Member to obtain necessary medical care and services reimbursed by Medicaid or Medicare.

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

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

Prior Approval: Except for certain pre-approved Covered Services, all Covered Services require Hamaspik CHOICE's advance or prior approval. Your care manager will review your health care needs and confer with your physician to determine those medically necessary and authorized Covered Service in your PCSP.

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

Telehealth: The use of electronic information and communication technologies by telehealth providers to deliver health care services. Telehealth can include the assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a Member. Telehealth does not include delivery of health care services by means of audio-only telephone communication, fax machines, or electronic messaging alone. However, the use of these technologies is not precluded if used in conjunction with other telemedicine technology or remote patient monitoring.

Appendix: Notice of Privacy Practices

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

Our Uses and Disclosures

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

Help manage the health care treatment you receive

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

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

Run our organization

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

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

Pay for your health services

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Your Rights

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

Get a copy of health and claims records

You can ask to see or get a copy of your health and claims records and other health information we have about you. You may request this by describing the information you want to review and the format in which you want to receive it in writing to Hamaspik CHOICE at:

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

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may refuse your request in certain limited instances. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Contact us by phone if you have questions about how to do this.

We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

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

Ask us to limit what we use or share

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

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

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your privacy rights by contacting the Hamaspik CHOICE Compliance Officer by phone at: 845-503-0569, or by email at: corporatecompliance@hamaspikchoice.org.

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

We will not retaliate against you for filing a complaint.

Your Choices

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

we will follow your instructions.

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

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

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

In the following circumstances, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Responsibilities

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

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

Additional Information. If you have any questions or would like additional information about this notice, please contact the Hamaspik CHOICE Compliance Officer by phone at: 845-503-0569, or by email at corporatecompliance@hamaspikchoice.org

Effective Date. This Notice of Privacy Practices is effective July 21, 2014.