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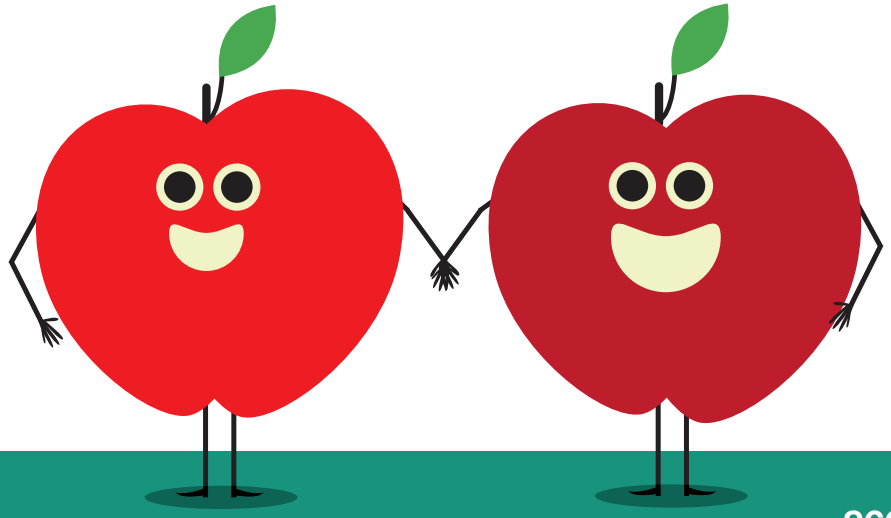
Live Well with
AgeWell
NEW YORK

Medicaid Managed Long Term Care (MLTC)

Member Handbook



Working with you hand-in-hand

866.586.8044
agewellnewyork.com

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Welcome

Thank you for choosing AgeWell New York as your partner in health care.

It is our privilege to serve you. For your convenience, we are providing you with this Member Handbook (this "Handbook") and a Provider Directory. Our goal is to provide you with outstanding care and to help keep you independent for as long as possible. Please keep this Handbook as a reference, as it includes important information regarding AgeWell New York and the advantages of our program.

One of the benefits of membership in AgeWell New York is having a Care Manager assigned to you to help you manage your care. We understand how complex it may be to access the right services, at the right time, and we are here to help. Your Care Manager will assist in answering any questions you may have regarding health care services you may need. You may contact your Care Manager by calling Member Services at **1-866-586-8044 (1-800-662-1220 TTY),** Monday through Friday from 8:00 am – 8:00 pm. Your Care Manager and Member Services specialists will work with your health care providers to ensure that you receive the care that you need in a timely manner. Should you call after normal business hours, your call will be forwarded to a member of the Care Management team.

Please note that a copy of this Member Handbook is also available in other prevalent languages such as Chinese, Russian, and Spanish and Korean. Should you require a large print, or audio copy of this Handbook, it can also be provided. Please contact your Care Manager.

You will receive a copy of your Enrollment Agreement from your Nurse Care Manager. Please keep a copy of this agreement for your records.

In the event of a medical emergency, please dial 911 or proceed to the nearest hospital. Be sure to bring any pertinent information with you.

Important Phone Numbers for AgeWell New York Managed Long Term Care Plan

AgeWell New York
Member Services (24 hours a day/7 days per week) 1-866-586-8044
AgeWell New York TTY 1-800-662-1220
Care Manager 1-866-586-8044

What to Do in a Medical Emergency
Call 911 or go to the nearest Emergency Room 911

To File a Grievance or Appeal, please call 1-866-586-8044
or write to:
AgeWell New York Grievances and Appeals
1991 Marcus Avenue, Suite M201
Lake Success, NY 11042

New York State Department of Health
Bureau of Managed Long Term Care
New York State Department of Health (Complaints) 1-866-712-7197

New York Medicaid Choice 1-888-401-6582
Monday to Friday, 8:30am – 8:00pm ..... or TTY: 1-888-329-1541
Saturday, 10:00am – 6:00pm

Member Services: Just a Toll-Free Phone Call Away (1-866-586-8044)

AgeWell New York wants you to understand your plan and receive the best possible care available. The Member Services department exists to allow you to do so. You may call Member Services to reach your Care Manager, ask questions about your covered benefits, obtain information about services and/or appointment times, replace a lost ID card, or to arrange medical transportation. If you have a concern about any aspect of your care coordinated by AgeWell New York, Member Services is there to help.

Member Services specialists are available by telephone to help you answer questions you may have and will work directly with your care team to arrange for authorized services.

Interpreter Services

AgeWell New York is dedicated to ensuring that our members are part of the care planning process. To that end, your Care Manager will ensure that, if you speak a language other than English, materials you receive are translated into the language you speak. AgeWell New York offers written information in the most prevalent languages of our members (English, Spanish, Russian and Chinese.) Our Care Team members speak a variety of languages, but if you speak a language that our staff does not know, we can access an oral interpretation service (Language Line) to ensure we can communicate with you and that your questions are answered. Written translation of the AgeWell New York materials is also available to all our members in different languages. A taped version of our Member Handbook is also available upon request.

For additional information regarding interpreter services, please call Member Services at 1-866-586-8044.

For Members Who Are Visually Impaired

For members who are visually impaired, large print handbooks or audio recordings are available upon request. Please let us know your needs for assistance.

For Members Who Are Hearing Impaired

Members who are hearing impaired should call the AT&T Relay Service operator at 1-800-662- 1220. The Operator will facilitate the calls between hearing-impaired members and Member Services specialists.

Joining AgeWell New York

Enrollment in AgeWell New York is voluntary. Your expected coverage date will be stated in your Enrollment Agreement. In general, coverage starts the first day of the month following your signing the Enrollment Agreement. If you are new to needing Medicaid Community-Based Long Term Care Services, you will need to be evaluated by a registered nurse from the New York State Conflict-Free Evaluation and Enrollment Center (CFEEC). This nurse will determine whether you are eligible for the community based long term care services provided under the Managed Long Term Care (MLTC) program.

As part of the enrollment process, and following the initial membership assessment telephone call, a Registered Nurse from AgeWell New York will come to your home. During this meeting, the following will occur:

- A comprehensive health assessment must be conducted within thirty (30) days of your request for enrollment.
- Your home environment will be assessed for safety.
- Rules and responsibilities of plan membership will be explained.
- Assistance will be provided in completing the enrollment process.

Eligibility Criteria

A potential member is eligible to enroll into AgeWell New York if he or she:

- Is at least 21 years of age or older;
- Is a resident of Westchester, Bronx, New York, Brooklyn, Queens, Nassau or Suffolk counties;
- Is determined eligible for Medicaid by the Local District of Social Service (LDSS) or entity designated by the State.
- Is determined eligible for MLTC by AgeWell New York, and/or entity designated by the New York State Department of Health (NYSDOH), using the Uniform Assessment System (UAS). The applicant must demonstrate a documented functional or clinical need for one of the Community Based Long Term Care Services, identified below;
- Is expected to require one of the following Community Based Long Term Care Services (CBLTCS) covered by AgeWell New York, for more than 120 days from the effective enrollment date:
    - Nursing services in the home;
    - Therapies in the home;
    - Home health aide services;
    - Personal care services in the home;
    - Adult day health care;
    - Private duty nursing; or
    - Consumer Directed Personal Assistance Services (CDPAS).

– With the exception of those eligible for permanent nursing home placement, is capable at the time of enrollment of remaining in or returning to his/her home and community without endangering his/her health and safety, based upon criteria provided by NYSDOH.

You will only be enrolled into AgeWell New York once it has been determined that you are eligible, a comprehensive assessment of your needs is completed, and you sign the enrollment agreement.

Denial of Enrollment

AgeWell New York may find a prospective member ineligible to enroll in AgeWell if he/she does not meet the age requirements, is not a resident of the AgeWell service areas, or is not eligible for Medicaid. If you do not meet the eligibility criteria, AgeWell New York will recommend denial of your enrollment to NY Medicaid Choice (NYMC), if you do not choose to withdraw your application. Only NYMC may deny enrollment and will notify you of your rights.

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

If you are determined to be clinically ineligible for AgeWell New York, you will be advised and you may withdraw your application. Clinical ineligibility means that, based on the assessment completed by the AgeWell New York registered nurse, you do not meet one or more of the following criteria:

- You do not meet health and safety criteria; and/or
- You do not require Community-Based Long Term Care Services for more than 120 days.
- You do not require nursing home level of care (Medicaid Only)

If you do not withdraw your application, your application will be processed as a proposed denial, pending review by NYMC.

Your Benefits as an AgeWell New York Member

One of the most important benefits for all AgeWell New York members is having a personal Care Manager to assess your needs and coordinate your services. With AgeWell New York, you truly have a partner in care and our goal is to aid in your wellness. Your care manager will be a registered nurse or a social worker who will work with you to seek and coordinate solutions to meet your health and long term care needs. Your care manager will create an individual care plan, also referred to as a person centered care plan that will outline the services that are medically necessary for you to receive. Your Care Manager will authorize for you to start or continue receiving services, as well as make receiving these services as seamless as possible. Your Care Manager will work with your primary care physician and other health care providers, to coordinate both your covered and non-covered services. Your care manager will also provide health education to you. Additional information regarding health education is also available on our website www.agewellnewyork.com.

AgeWell New York will authorize payment to providers of covered services; therefore you are not liable for the costs of authorized covered services. The providers listed in the Provider Directory are paid directly by AgeWell New York for covered services they provide to you.

Services are covered when they are medically necessary. Medically necessary means services or items needed to diagnose and treat a medical condition. When determined medically necessary, the services listed below are covered by AgeWell New York:

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

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

Adult Day Health Care- Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services. Adult day health care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities which are a planned program of diverse meaningful activities, and other ancillary services.

Nursing Home Care- Care provided in a nursing home when a member is eligible for institutional Medicaid, and placed permanently in the home. [1]

Podiatry- Services by a Podiatrist that include routine foot care when it is medically necessary for the member, such as serious localized illness or diabetic foot care.

Non-Emergency Transportation- Transport by ambulance, ambulette, taxi or livery service or public transportation, at the appropriate level the member's condition requires, for medically necessary trips such as to dialysis or medical appointments.

Dental Services- Includes services such as preventive, prophylactic, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.

Audiology/Hearing Aids/Hearing Aid Batteries- Audiology services include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations, if indicated. Hearing aid services include selecting, fitting and dispensing of hearing aids, hearing aid checks following dispensing and hearing aid repairs. Products include hearing aids, ear molds, batteries, special fittings and replacement parts.

Durable Medical Equipment- Includes medical and surgical equipment and supplies, such as orthopedic footwear, hearing aid batteries, diabetic supplies, and incontinence supplies as key examples. Durable medical equipment is devices and equipment, which have been ordered by a practitioner in the treatment of a specific medical condition.

Prosthetic and Orthotic Appliances and Devices – Prosthetic appliances and devices which replace any missing part of the body. Orthotic appliances and devices are used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body.

Rehabilitation Therapies- Rehabilitation services provided by licensed and registered therapists, outside the home[2], for the purpose of maximum reduction of physical or mental disability and to restore the member's best functional level.

Respiratory Therapy- Means the performance of preventive, maintenance and rehabilitative airway-related techniques and procedures.

Optometry/Eyeglasses- Includes the services of an optometrist and ophthalmic dispenser. It includes eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes, and low vision aids. The optometrist may perform an eye exam to detect visual defects and eye disease as necessary or as required by the member's condition. Limitations of service authorizations can be discussed with the member's Care Manager.

Nutrition and Dietary Services (including Nutritional Supplements) - The assessment of nutritional needs or the planning for appropriate meals and nutritional supplements to meet the member's needs. Supplements include enteral and parenteral formulas. [3]

Home Delivered/Congregate Meals – Meals provided in accordance with each individual member's plan of care. Congregate meals are meals delivered at a group setting such as day care.

Personal Care- Some or total assistance with such activities as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks.

Personal care must be medically necessary, ordered by the member's physician and provided by a qualified person as determined by regulation, in accordance with the plan of care.

Social Services/Environmental Supports- Services and items that support the medical needs of the member and are included in a member's plan of care. These services and items include, but are not limited to, the following; home maintenance tasks, homemaker/chore services, housing improvement and respite care.

Personal Emergency Response Systems- An electronic device which enables certain high-risk patients to secure help in the event of an emergency.

Private Duty Nursing Services –are medically necessary services provided to members at their permanent or temporary place of residence, by properly licensed registered professional or licensed practical nurses (RNs or LPNs), in accordance with physician orders. Such services may be continuous and may go beyond the scope of care available from certified home health care agencies (CHHAs.)

Consumer Directed Personal Assistance Services (CDPAS) –The New York State Medicaid program permits Medicaid-eligible persons to hire, monitor, and terminate their own home caregivers (personal assistants). Instead of an outside vendor or agency managing their care, CDPAS gives MLTC eligible individuals independence and control. Certain guidelines apply to eligibility for CDPAS and individuals who can serve as personal assistants.

Telehealth - Effective January 1, 2016, health care services delivered by telehealth are covered. 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, or hospice.

[1] Nursing Home Care is covered for individuals who are considered a permanent placement, provided you are eligible for institutional Medicaid coverage.

[2] Outpatient Physical Therapy, Occupational Therapy and Speech Therapy are limited to twenty (20) visits per calendar year, of each therapy type except for children under 21 and individuals with developmental disabilities.

[3] Enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) individuals who cannot chew or swallow food and must obtain nutrition through formula nasogastric, jejunostomy, or gastrostomy tube feeding; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Members are not responsible for payment to providers for authorized services.
If you receive a bill from a provider, please notify Member Services at 1-866-586-8044.

Covered Services and Authorizations

The chart below lists the benefits covered by AgeWell New York MLTC and indicates whether authorization is required prior to receiving services as well as whether your physician must be involved in arranging the service. Your Care Manager will assist you with arranging these.

AgeWell New York Benefit	Physician Order Required	AgeWell New York Authorization Required
Home Health Care	✓	✓
Adult Day Health Care	✓	✓
Personal Care	✓	✓
Durable Medical Equipment	✓	✓
Medical/Surgical Supplies	✓	✓
Prosthetics	✓	✓
Orthotics	✓	✓
Enteral and Parenteral Supplements	✓	✓
Personal Emergency Response System		✓
Non-Emergent Transportation		✓ Call National MedTrans to Schedule
Podiatry (if medically necessary)		✓
Dentistry		✓ Care Manager can assist in arranging for this service
Optometry/Eyeglasses		✓ Care Manager can assist in arranging for this service
Audiology/Hearing Aids		✓
Hearing aid Batteries		✓
Home Delivered/Congregate Meals		✓
Social Day Care		✓
Outpatient Therapy	✓	✓
Respiratory Therapy	✓	✓
Nutritional Counseling	✓	✓
Social Supports and Home Modifications (if medically necessary)		✓
Private Duty Nursing	✓	✓
Nursing Home Care	✓	✓
Consumer Directed Personal Assistance Services	✓	✓

Services Not Covered by AgeWell New York

If you have Medicare benefits, your membership in AgeWell New York does not affect your Medicare eligibility or coverage. You can continue to receive non-covered services through your current providers. In addition, you do not need prior authorization to receive services covered by Medicare. Even though these services are not covered by AgeWell New York, your Care Manager can help you arrange for them, in the event they are necessary.

The following services are not covered by AgeWell New York but are covered by Medicare and/or Medicaid on a fee-for-service basis:

- Inpatient/Outpatient Hospital Services
- Physician Services including services provided in an office setting, a clinic, a facility, or in the home. This includes nurse practitioners and physician assistants acting as physician extenders.
- Laboratory Services
- Chiropractic Care
- Emergency Transportation
- Chronic Renal Dialysis
- Medication - Prescription/Nonprescription
- Office for People with Developmental Disabilities (OPWDD) Services
- X-Ray/Radiology Services
- Rural Health Clinic Services
- Mental Health Services
- Alcohol and Substance Abuse Services
- Family Planning Services
- Hospice Services*

Although these services are not part of the AgeWell New York benefit package, your Care Manager will help arrange and coordinate them, as needed.

AgeWell New York MLTC is always a secondary payer to Medicare**.**

*Members who have been served by AgeWell New York and who subsequently elect hospice as a result of a qualifying illness or condition may continue to be enrolled in the AgeWell New York MLTC plan. Upon hospice enrollment, AgeWell New York will reevaluate your person centered service plan in consultation with the hospice and your physician to coordinate needed services and avoid duplication or conflict.

Your Care Team

As part of your enrollment in AgeWell New York, you will be assigned an experienced Care Manager who will help customize your plan of care to meet your needs. Your Care Manager will be your main point of contact for all issues pertaining to the services you receive. Your plan of care will include services that are covered and are deemed medically necessary. You are encouraged to, and will have the opportunity to, take part in establishing your plan of care as will your physician and others you authorize to be part of the care planning process. AgeWell New York encourages the support of your family or other caregivers in developing a care plan that will fit your needs. In addition, your plan of care may include non-covered services that your Care Manager will help you arrange.

You will receive your individual, person centered plan of care in writing. Your plan of care will include a list of services that are authorized to be provided, including how frequently you will need these services and the duration of time these services will be authorized. It will also be explained what services are offered 24 hours-a-day/seven-days-a-week. All services must have prior authorization unless there is an instance of a true emergency. Also, your person centered plan of care addresses your personal goals, and your health and safety risk factors. As part of this plan, AgeWell New York maintains back-up plans for you to ensure that needed assistance will be provided in the event that regularly scheduled services are temporarily unavailable.

Your Care Manager will speak with you monthly and will update your plan of care as needed. At least every 6 months, your Care Manager or another registered nurse of the AgeWell New York team will come to your home to reassess your needs and adjust your care plan, if needed. In addition, you will always be reassessed when there is a significant change to your health status. Should you wish to discuss a change in your care plan, you should contact your Care Manager by calling Member Services at 1-866-586-8044. In addition to your Care Manager, a Member Services specialist can assist you with information regarding your plan of care, confirm service authorizations and address other issues or concerns you may have.

Requesting New or Additional Services

Requests for new or additional covered services can be obtained through your Care Manager by you or your provider. Requests can be made orally or in writing. New or additional services require the review and authorization of your Care Manager. Some requests require a medical necessity determination to ensure the requested service is most appropriate for your condition and are medically necessary. In some cases, Service Authorizations will be sent to you and your service provider in writing.

You or your provider's request for new or additional services will be handled one of the following ways:

Prior Authorization (New Services)

A request by you or a provider on your behalf, for coverage of a new service 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 you is considered a Prior Authorization.

Standard Prior Authorization

- For **standard Prior Authorizations**, we must make a Service Authorization Determination and notify you by phone and in writing as fast of your condition requires and no more than three (3) business days after we receive all necessary information, but no more than fourteen (14) days after the date we received your request.

Expedited Prior Authorization

- You can request an **expedited Prior Authorization** if your provider indicates that a delay would seriously jeopardize your life, health or ability to attain, maintain or regain maximum function. For an expedited Prior Authorization we must make a Service Authorization Determination and notify you by phone and in writing within three (3) business days after the date we received your request.

Concurrent Review (More of the Same Services)

- This means a request by you or a provider on your 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.

Standard Concurrent Review

- For **standard Concurrent Reviews**, we must make a Service Authorization Determination and notify you by phone and in writing as fast as your condition requires and no more than one (1) business day after we receive all necessary information, but no more than fourteen (14) days after the date we received your request.

Expedited Concurrent Review

- You can request an **expedited Concurrent Review** if your provider indicates that a delay would seriously jeopardize your life, health or ability to attain, maintain or regain maximum function. For an expedited Concurrent Review we must make a Service Authorization Determination and notify you by phone and in writing within one (1) business day after we receive all necessary information, but no more than three (3) business days after the date we received your request.

- In cases of a request for Medicaid covered home health care services following a hospital or skilled nursing facility admission, we will decide your Service Authorization Request within one (1) business day after receiving all necessary information; **except** when the day after your request falls on a weekend or holiday; in that case, we will decide seventy- two (72) hours after receiving all necessary information; but no more than three (3) business days after the date we received your request.

Duration and frequency of services will be outlined in your individual plan of care. You or your provider can request to amend the duration or frequency of covered services. AgeWell New York will make a clinical determination and will inform you and your provider in writing. If the services you requested are not authorized, you will receive an Initial Adverse Determination notice by mail which will explain our decision. You or your provider may appeal our decision.

For more information, please refer to the Grievances and Appeals section of this manual.

An extension of up to 14 calendar days may be requested by a member or provider on a member'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 member's interest. In all cases, the extension reason will be well-documented.

AgeWell New York will notify a member of a plan-initiated extension of the deadline for review of his or her service request. We will explain the reason for the delay, and how the delay is in the best interest of the member. AgeWell New York shall request any additional information required to help make a determination or redetermination, and help the member by listing potential sources of the requested information.

Identification (ID) Card

You will receive your AgeWell New York identification (ID) card within 14 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times. In addition please have your Medicare, Medicaid and any third party insurance cards with you, as you will need them to receive care. If your card becomes lost or is stolen, please contact Member Services at, 1-866-586-8044.

Below is a sample of what your AgeWell New York ID card will look like.

Provider Network

As a member of AgeWell New York, you will receive a Provider Directory that identifies providers that participate in the AgeWell New York Provider Network. For assistance in choosing a provider from the Provider Directory, please contact your Care Manager. AgeWell New York has selected high quality providers that will be committed to helping you live independently for as long as possible. If your current provider is not in our network and you would like them to be, please contact your Care Manager and we will make every effort to accommodate your request. If your provider is leaving the network, you will receive written notification.

Transitional Care

If you are a new enrollee and you are currently receiving care for an ongoing course of treatment from a provider that does not participate in the AgeWell New York Provider Network, you may continue to receive care from your current provider for a transitional period of up to 60 days. The provider must accept payment from AgeWell New York at the negotiated rate, adhere to AgeWell New York quality assurance and other policies, and provide medical information about the care provided to you to AgeWell New York Care Managers.

Should your health care provider leave the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the rate paid by AgeWell New York, adheres to AgeWell New York quality assurance and other policies, and provides medical information about your care to AgeWell New York.

Continuity of Care

If you are transitioning from a Medicaid community-based long term care program, AgeWell New York must continue to provide services authorized under your pre-existing service plan for a minimum of ninety (90) days.

Out of Network Care

Payment will not be made for out-of-network providers not authorized in advance by AgeWell New York. Should you wish to obtain care from a provider not in the AgeWell New York Provider Network, your Care Manager will review the circumstances and provide authorization, if appropriate. You must inform your Care Manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your Care Manager should be contacted to assist you in arranging services. Please note: if you seek care from providers who do not participate in the AgeWell New York Network without prior authorization, you will be financially responsible for payment of these services.

Leaving the AgeWell New York Service Area

AgeWell New York service area is Bronx, Brooklyn, Manhattan, Queens, Nassau, Suffolk and Westchester. If you are planning to spend time away from your home, please let your Care Manager know immediately. If you are planning on being out of the service, we will make every effort to assist you in arranging temporary services. If you leave the service area for more than 30 consecutive days, we must start the involuntary disenrollment process and you will no longer be eligible for MLTC coverage. In this case, you should call your Care Manager to discuss your options.

Medicaid Spenddown/Surplus/Net Allowable Monthly Income (NAMI)

Some members may have a monthly spenddown/surplus to be eligible for Medicaid services. The spenddown amount is determined by the Local Department of Social Services or entity designated by the NYSDOH/Human Resource Administration (HRA). If this applies to you, payments are to be made to AgeWell New York, on a monthly basis. If you have a spenddown amount owed to AgeWell New York and you do not submit payments, you may be disenrolled from AgeWell New York. Spenddown payments can be in the form of check or money order (not cash), and should be sent to the following address:

AgeWell New York
Attn: Finance Department, Member Accounts
1991 Marcus Avenue, Suite M201
Lake Success, NY 11042

If you are a permanently placed member in a nursing home, you are required to contribute your Net Allowable Monthly Income (NAMI) towards the cost of your care. You are required to remit this amount to the nursing home directly.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct 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 make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents.

Emergency Care

Emergency Care means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency care. However, you should notify AgeWell New York within 24 hours of the emergency. You may be in need of long term care services that can only be provided through AgeWell New York.

If you are hospitalized, a family member or other caregiver should contact AgeWell New York within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact AgeWell New York so that we may work with them to plan your care upon discharge from the hospital.

Nursing Home Placement

There may be instances in which your condition requires permanent placement in a nursing home. Your Care Manager will work with you, and other parties involved in your plan of care, to facilitate placement in a network participating facility. **You must be eligible for institutional Medicaid.** Limitations apply for members who are eligible for community Medicaid only. If you choose placement in an out of network facility, you must be transferred to a plan that contracts with the nursing home of your choice.

Veterans Protections

If you are a veteran, spouse of a veteran, or Gold Star parent enrollee in need of long term placement, you may receive care from a contracted veteran's home, in our provider network. If we are not contracted with a veteran's home, and unless you indicate otherwise, we will direct you to the enrollment broker. If you desire to receive care from a veteran's home, we will allow you to do so, on an out of network basis, until you transfer to another Plan with an in-network veteran's home.

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

Member Rights/Responsibilities

Staff of AgeWell New York will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

As a Member, you have the right to:

- Receive medically necessary care;
- Timely access to care and services;
- Confidentiality of your medical records and privacy when you get treatment;
- Get information on your diagnosis and on available treatment options and alternatives, presented in a manner and language you understand from a health care professional;
- Get information in a language you understand; you can get oral translation services free of charge;
- Get information from a health care professional necessary for you to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get 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, and to be informed about the medical consequences of those decisions;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status, or religion or any other basis prescribed by law;
- Be told where, when and how to get the services you need from your plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan 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 a New York State External Appeal, where appropriate;
- Someone to speak for you about your care and treatment.
- Have the right to seek assistance from the Participant Ombudsman program, ICAN.
- Have the right to receive information about AgeWell New York and managed long term care in a manner which does not disclose you as participating in the MLTC Plan, provided that including AgeWell New York's name is not considered a violation of this right.

As a Member, you are responsible for:

- Receiving covered services through AgeWell New York;
- Using AgeWell New York network providers for covered services to the extent network providers are available;
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies;
- Being seen by your physician, if a change in your health status occurs;
- Sharing complete and accurate health information with your health care providers;
- Informing AgeWell New York staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions;
- Following the plan of care recommended by the AgeWell New York staff (with your input);
- Cooperating with and being respectful with the AgeWell New York staff and not discriminating against AgeWell New York staff because of race, color, national origin, religion, sex, age, mental or physical ability, sexual orientation or marital status;
- Notifying AgeWell New York within two business days of receiving non-covered or non pre-approved services;
- Notifying your AgeWell New York health care team in advance whenever you will not be home to receive services or care that has been arranged for you;
- Informing AgeWell New York before permanently moving out of the service area, or of any lengthy absence from the service area;
- Your actions if you refuse treatment or do not follow the instructions of your caregiver;
- Meeting your financial obligations.

Addressing Your Problems or Concerns

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

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

To file a grievance or to appeal a plan action, please call: *1-866-586-8044* or write to:

AgeWell New York
Grievances and Appeals Department
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042

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

What is a Grievance?

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

The Grievance Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information

2. For all other types of grievances, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the grievance. The review period can be increased up to 14 days if you request it or if we need more information and the delay is in your interest.

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

How do I Appeal a Grievance Decision?

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

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

What is an Action?

When AgeWell New York 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 grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);

- Describe how to file an internal appeal and the circumstances under which
- you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any that must be provided by you and/or your provider in order for us to render a decision on appeal.

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

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

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

How do I Contact my Plan to file an Appeal?

We can be reached by calling 1-866-586-8044 or writing to:

AgeWell New York
Grievances and Appeals Department
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who was 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 must request a Fair Hearing to continue to receive these services while your appeal is decided. We must continue your service if you ask for a Fair Hearing no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a Fair Hearing, and to ask for aid to continue, see the Fair Hearing Section below.

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

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

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

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

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

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

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 60 calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your Internal Appeal.

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

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 60 calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides your appeal and then ask for a Fair Hearing. In either case, the same 60 calendar day deadline applies. AgeWell New York will not act in any manner so as to restrict your right to a fair hearing or try to influence your decision to pursue a fair hearing.

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

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

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

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx
- Mail a Printable Request Form:

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

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

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

- Request in Person:

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

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

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

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."

You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

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

It is your right to contact the Department of Health if you feel that you were treated unfairly by AgeWell New York. The New York State Department of Health can be contacted at the following address:

New York State Department of Health
Bureau of Managed Long Term Care
One Commerce Plaza (Room 1624)
Albany, New York 12210
1-866-712-7197

Voluntary Disenrollment

You may voluntarily disenroll from the plan at any time, for any reason. After you provide us notice of your desire to disenroll, AgeWell New York will give you written notice confirming we received your intent to disenroll and you will be given an effective date for termination of your coverage. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. You will be asked to sign a Voluntary Disenrollment Form. AgeWell New York will continue to provide covered benefits until the effective date of disenrollment and will make all necessary referrals to alternative services, no longer covered by AgeWell New York, after the disenrollment date.

Please note that if you disenroll and you continue to need long term care services, you are no longer able to obtain such services through the Medicaid fee-for-service (FFS) program. You can join another MLTC, mainstream managed care plan (if Medicaid only) or a New York State waiver service program, if eligible.

Involuntary Disenrollment

You may be involuntarily disenrolled from the plan under very limited circumstances. AgeWell New York reserves the right to terminate your coverage for any of the following reasons:

- AgeWell New York **must** initiate disenrollment if:
- We know you no longer reside in the service area;
- You have been absent from the service area for more than thirty (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 institutional Medicaid;
- You are no longer eligible to receive Medicaid benefits;
- You are no longer eligible for MLTC because you are assessed (determined using the assessment tools prescribed by DOH) as no longer demonstrating a functional or clinical need for community-based long term care services or, for non-dual eligible enrollees, in addition, you no longer meet the nursing home level of care;
- You are incarcerated.

AgeWell New York **may** initiate involuntary disenrollment if:

- You, your family or other person in your home engages in conduct or behavior that seriously impairs our ability to furnish services to you or another member;
- You (or your legal guardian) fail to pay for or make arrangements satisfactory to AgeWell New York to pay the amount of your spenddown/surplus, as determined by the LDSS/HRA;
- You fail to complete and submit any necessary consent or release; and
- You provide AgeWell New York with false information, otherwise deceive AgeWell New York or engage in fraudulent conduct with respect to your membership.

Before being involuntarily disenrolled, AgeWell New York will obtain the approval of NYMC or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need community based long term care services, you will be required to choose another MLTC plan or you will be auto-assigned to another MLTC to provide you with coverage for needed services.

Re-Enrollment Provisions

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

Notice of Privacy Practices

The Notice of Privacy Practices (this "Notice") describes how protected health information ("PHI") about you may be used or disclosed, your rights regarding PHI, information regarding how you may gain access to your PHI, and the legal duties of AgeWell New York to protect member PHI.

HIPAA Privacy Regulations

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

- The Privacy Regulations define PHI as:
- Information that identifies or can be used to identify a member.
- Information that either comes from the member or has been created or received by a health care provider, a health plan, the member's employer or a clearinghouse.
- Information that has to do with the physical or mental health or condition of a member, provision of health care to a member, or payment for provision of health care to a member.

You have the right to request a personal representative to act on your behalf, and AgeWell New York will treat that person as if the person were you. Please be aware, however, that unless you have applied restrictions, your personal representative will have full access to your entire PHI. You must make a request in writing if you would like someone to act as a personal representative. Please contact Member Services for more information at 1-866-586-8044.

Our Pledge Regarding Health Information

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

We are required by law to:

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

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A new Notice that includes the changes and new effective dates will be mailed to you at the address in your medical record. You may also request a copy by calling Member Services at 1-866-586-8044. In addition we will update the information on the AgeWell New York website.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with AgeWell New York or with the Secretary of Health and Human Services.

To file a complaint with AgeWell New York or to appeal a decision about your PHI, please write or call Member Services at:

AgeWell New York
Member Services Department
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042

1-866-586-8044

To file a complaint with the Secretary of Health and Human Services:

Office of Civil Rights
Department of Health and Human Services
26 Federal Plaza, Suite 3313
New York, NY 10278

How We May Use and Disclose Your Medical Information

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

- To assist in the coordination of medical treatment and services on behalf of a member;
- When updating a member's service plan;
- So that services received by a member may be reviewed for payment;
- In order to make decisions about claims requests and appeals for services provided to members;
- To contact a member for appointment reminders;
- For health care operations, such as using the information in a medical record to review the care and results in a member's case and other cases like it for quality improvement;
- To send members information about one of our disease or case management programs;
- In order to answer a customer service request;
- In connection with an investigation into any fraud or abuse cases, and to make sure required rules are followed;
- To contract with business associates who will provide services to AgeWell New York using a member's PHI ("Business Associates"). Services our Business associates may provide include dental services for members, a copy service that makes copies of medical records, and computer software vendors. Business Associates will only use member PHI to do the job we have asked them to do. All Business Associates must sign a contract to agree to protect the privacy of member PHI. In addition, AgeWell New York will provide Business Associates with changes to this Notice;

- To a family member, other relative, close friend, or other personal representative that a member chooses. The extent of the disclosure of the PHI will be based on how involved the chosen person is in a member's care, or payment that relates to a member's care;
- If law enforcement officials ask us to, such as in order to respond to a subpoena;
- For public health activities allowed or required by law, such as disease control;
- When requested by researchers when an institutional review board or privacy board has followed the HIPAA information requirements;
- To identify a deceased person, determine a cause of death, or to perform other coroner or medical examiner duties allowed by law;
- To share information with funeral directors, as allowed by law, as well as organizations that handle organ donation and transplants;
- If we feel it is needed to prevent or reduce a serious and likely threat to the health or safety of a person or the public;
- If a member is an organ donor, for the release of minimally necessary member PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- If a member is or was in the Armed Forces, for activities believed necessary by appropriate military command authorities;
- To share PHI with the Secretary of the U.S. Department of Health and Human Services. This happens when the Secretary looks into or decides if AgeWell New York is in compliance with the HIPAA Privacy Regulations.

When required to, we will obtain your authorization before disclosing any of your information. Except with regard to disclosures for treatment, only the minimally necessary information will be revealed during any disclosures.

Your Rights Regarding Your Medical Information

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

Right to Inspect and Obtain a Copy

You have the right to view and get a copy of your enrollment, claims, payment and case management information on file with AgeWell New York. This file of information is called a designated record set. AgeWell New York will provide you with one copy of your designated record set in any 12-month period without charge.

If you would like a copy of your PHI, you must send a written request to:

AgeWell New York
Member Service Department
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042

We will answer your written request in thirty (30) calendar days but please understand that the request may take up to sixty (60) days to process.

AgeWell New York does not keep complete copies of your medical records. If you would like a copy of your medical record from a certain provider, such as your podiatrist, you must contact that provider. That provider will instruct you on how to obtain a copy of your medical record and costs related to obtaining that record.

We have the right to keep you from having or seeing all or part of your PHI for certain reasons, such as an instance that could cause you harm. Or, if the information was gathered or created for research or as part of a civil or criminal proceeding. We will tell you the reason in writing if we choose to keep certain PHI from you. We will also give you information about how you can file an appeal if you do not agree with our decision.

Right to Amend Your Medical Information

You have the right to ask that information in your health record be changed if you believe it is incorrect. Please contact the Member Services Department in writing to request the change, and state the reason why you are asking for a change.

If the change you request is in your medical record, please contact the provider who wrote the record. That provider will explain what you need to do to have the medical record changed.

We will answer your request for a change to your records within thirty (30) days of when we receive it. Please understand that it can take up to sixty (60) days to process your request. AgeWell New York reserves the right to deny the request for change. We will send you a written reason for the denial if:

- The information was not created or entered by AgeWell New York;
- The information is not kept by AgeWell New York;
- You are not allowed, by law, to see and copy that information;
- Is accurate and complete.

Right to an Accounting of Certain Disclosures of Your Protected Health Information

You have the right to know how often your PHI has been disclosed. This is a list of times we shared your information when it was not part of payment and health care operations. We are not required to account for routine disclosures, including disclosures to you or disclosures you have authorized.

Most disclosures of your PHI by our Business Associates or us will be for payment or health care operations. Please contact the Member Services Department for a request form. All requests for an accounting of PHI disclosures must be made in writing.

AgeWell New York will provide you with one copy of your designated record set in any 12- month period without charge. For additional accountings, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Confidential Communications

You have the right to ask that we communicate with you in a specific way or in a certain location. For example, you may ask that we send mail to an address that is different from your home address. You may request a form to change your contact information by contacting Member Services at 1-866-586-8044. Requests must be made in writing.

If you believe that your privacy rights have been violated, you may file a complaint with AgeWell New York or with the Secretary of Health and Human Services.

To file a complaint with AgeWell New York or to appeal a decision about your PHI, please write or call Member Services at:

AgeWell New York
Member Services Department
1991 Marcus Avenue, Suite M201
Lake Success, New York 11042

1-866-586-8044

If you are hearing impaired, please call us through the TTY number at 1-800-662-1220.

To file a complaint with the Secretary of Health and Human Services, send your written request to:

Office for Civil Rights
U.S. Department of Health and Human Services
26 Federal Plaza, Suite 3313
New York, NY 10278

Right to Receive a Copy of This Notice

You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time. To request a copy of this notice, you must call Member Services at 1-866-586-8044.

Right to Request Restrictions and Limitations of Use

Although it is AgeWell New York's policy to make only minimally necessary disclosures of your PHI, you have the right to request a limit on how many times your PHI is used. You have the right to request a restriction on the people who are able to obtain the information we disclose. However, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

All requests must be in writing. You may request the form by calling the Member Services Department at 1-866-586-8044.

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

You must provide us with written authorization to use or give out your PHI for reasons other than those listed above.

You will not experience a change in health care benefits or termination of coverage with AgeWell New York if you file a complaint against AgeWell New York.

Important Phone Numbers for AgeWell New York

AgeWell New York

Member Services (24 hours a day/7 days per week) 1-866-586-8044

AgeWell New York TTY 1-800-662-1220

Care Manager 1-866-586-8044

What to Do in a Medical Emergency

Call 911 or go to the nearest Emergency Room 911

To File a Grievance or Appeal 1-866-586-8044
or write to:

AgeWell New York
Grievances and Appeals
1991 Marcus Ave., Suite M201
Lake Success, NY 11042

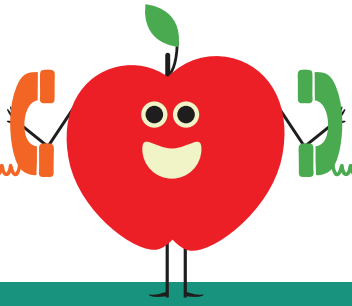
New York State Department of Health Bureau of Managed Long Term Care

New York State Department of Health (Complaints) 1-866-712-7197

Information Available on Request

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

Feel Well,
Live Well with
AgeWell
NEW YORK



We're here for your call.

Toll Free 1.866.586.8044 | TTY/TDD 1.800.662.1220
info@agewellnewyork.com | agewellnewyork.com