MEMBER HANDBOOK

Nascentia HealthOPTIONS

TOMORROW'S HEALTHCARE TODAY

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WELCOME to NASCENTIA HEALTH OPTIONS

We are glad that you chose Nascentia Health Options. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call on you, just call us at 888-477-HOME (4663).

About Nascentia Health Options

Nascentia Health Options is a Medicaid Managed long term care (MLTC) plan that brings people and resources together to better plan and deliver accessible, high quality health care services for you. As a key part of that effort, Nascentia Health Options has developed a respected network of area providers that are able to deliver the services you may require.

We encourage our members to take an active role in their own health care and we offer many choices in services and locations to assist in that effort. It's all part of our commitment to you.

Our goal is to help you live independently, in your own home, for as long as possible.

Enrollment in Nascentia Health Options is entirely voluntary. When you enroll in Nascentia Health Options you are required to use providers in the Nascentia Health Options network and obtain authorization from your Care Management Team for services covered by Nascentia Health Options.

HOW MANAGED LONG TERM CARE WORKS

The Plan, Our Providers, & You

No doubt you have seen or heard about the changes in health care. Many consumers now get their health benefits through managed care. Many counties in New York State offer a choice of managed long term care health plans.

Nascentia Health Options is a Medicaid Managed Long Term Care Plan. It is designed for people who are Medicaid eligible that need home and community based health and long term care services, like personal care, nursing, therapy, transportation, so that they can stay in their home and community as long as possible.

If you are eligible and live in one of our service area counties, you can choose to join a Medicaid managed long term care program.

Nascentia Health Options has a contract with the New York State Department of Health to meet the health care needs of people with Medicaid. In turn, we choose a group of health care providers to help us meet your needs. These home care agencies, day care programs, meals on wheels providers, dentists and

health care facilities are a few of the services included in our **provider network**. You'll find a list in our provider directory. If you don't have a provider directory, call Nascentia Health Options to get a copy.

Joining Nascentia Health Options is voluntary. To be eligible to join you must:

- Be eligible for Medicaid as determined by the Local Department of Social Services (LDSS)
- Are at least 18 years' old
- Reside in one of our approved Counties
- Be eligible for MLTC as determined by us or the entity designated by the DOH at enrollment
- Are capable, at the time of enrollment of returning to or remaining in your home and community safely, without jeopardy to your health and safety. (exception permanent nursing home enrollees)
- Are expected to require at least one of the following Community based Long term Care Services (CBLTCS) for more than 120 days from the date you join the plan.
    - Nursing Services in the home
    - Therapies in the home
    - Home Health Aide Service
    - Private Duty Nursing
    - Personal Care Services in the home
    - Consumer Directed Personal Assistance Services (CDPAS)
    - Adult Day Health Care

The potential that you may require acute hospital inpatient services or nursing home placement during the 120 days shall not be taken into consideration when determining an applicant's eligibility for enrollment.

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcohol and Substance Abuse Services (OASAS) or the State Office for People with Developmental Disabilities (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with the plan upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice Home and Community-Based Services waiver program or OPWDD Day Treatment Program.

Nascentia Health Options will not discriminate or deny enrollment based on your current health status, a change in your health status, or the cost of your covered services. Our goal is to keep you in your home as long as possible.

Nursing Home residents

- Permanently placed Nursing Home residents may voluntarily enroll
- Those permanently placed Nursing Home residents who enroll may continue to progress and eventually consider returning to the community with the services of the plan
- Nascentia Health Options, member, nursing home and physician will develop the person centered service plan of care to effectively transition to the community with appropriate plan services and supports

- Short term rehabilitation residents who have never been converted to permanent placement will need to have a CFEEC evaluation

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

Who is eligible for MFP?

To be eligible for MFP participation the individual must meet the following criteria:

- Have resided in a qualified institution (hospital, nursing home, or ICF/IID) for not less than 90 consecutive days (minus Medicare covered rehabilitative days) immediately prior to transitioning to the community;
- Be Medicaid eligible at least one day prior to discharge/transition;
- Meet the eligibility/enrollment criteria associated with a constituent program;
- Have health needs that can be met through services available in the community;
- Voluntarily consent and participate;
- Transition into a qualified residence.

What is a qualified residence?

A qualified residence is defined as:

- A home owned or leased by an individual or family member; or
- An apartment with an individual lease, with lockable access and egress, which includes living, sleeping, bathing, and cooking areas over which the individual or the individual´s family has domain and control; or
- A community-based residence in which no more than 4 unrelated individuals reside

You can ask your Care Manager or your Nursing Home for more information about *MFP/Open Doors*.

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.

Transitioning to Nascentia Health Options.
You may still join Nascentia Health Options even if you are in a course of treatment with a non-network provider. During this transition period of up to 90 days, you will continue with that provider as long as they accept the plan payment, adhere to our quality assurance standards, policies and procedures and provide medical information about your care to us.

When you join Nascentia Health Options you will be assigned to a Care Manager. This person will assist in arranging and coordinating care within and outside of our provider network. With Nascentia Health Options if you need home care, home delivered meals, or see a dentist your Care Manager will help you arrange it.

Nascentia Health Options is available to you every day and night. If you need to speak to someone after hours or weekends, contact our on-call staff at 888-477-HOME (4663) to assist you.

HOW TO USE THIS HANDBOOK

Whether you have joined or you may choose to join a managed long term care plan, this handbook will help. It will tell you how your managed long term care program will work and how you can get the most from Nascentia Health Options. This handbook is your guide to health services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know **right** away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this Handbook or call our Member Services unit.

HELP FROM MEMBER SERVICES

There is someone to help you at Member Services:

Monday - Friday	8:00 am - 4:30 pm
Phone:	888-477-HOME (4663)
TTY:	711

After regular business hours, you can reach on-call assistance at 888-477-HOME (4663)

You can call to get help **anytime you have a question.** You may call us, to ask about benefits and services, to get help with referrals, to replace a lost ID card, or ask about any change that might affect you or your family's benefits.

We offer **free sessions** to explain our health plan and how we can best help you. It's a great time for you to ask questions and meet other members. If you'd like to come to one of the sessions, call us to find a time and place that are best for you.

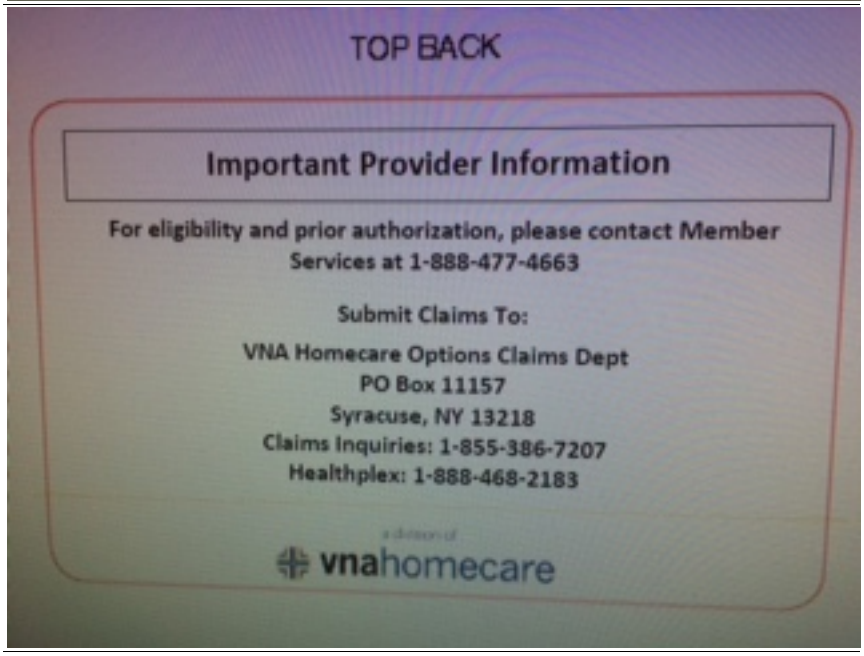
If you do not speak English, we can help. We want you to know how to use your health care plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP (Primary Care Provider) who can serve you in your language.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. Also, we have services like:

TTY 711
Information in Large Print
Names and Addresses of Providers Who Specialize in Your Disability

YOUR HEALTH PLAN ID CARD

After you enroll, we'll send you a welcome letter. Your Nascentia Health Options ID card should arrive within 14 days after your enrollment date. If anything is wrong, call us right away. Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should always carry your Medicaid benefit card and your Medicare card. You will need your Medicaid and Medicare cards to get services that Nascentia Health Options does not cover. These services include pharmacy benefits, hospital benefits, primary care physician and specialty physician visits.



PART I FIRST THINGS YOU SHOULD KNOW

Upon membership to Nascentia Health Options, your assigned Care Manager will visit you to assess your health care needs. The Care Manager in collaboration with you, your caregivers and the interdisciplinary team will develop a person-centered service plan that will address and meet your needs. Our goal is to keep you as healthy and independent as possible out in the community.

We will collaborate with your physician on your plan of care to ensure that you have the services you need to remain safely at home. **Your physician will be asked to provide signed orders for your services.**

Your Care Manager will authorize services covered by Nascentia Health Options. They will also coordinate those services that are not covered by Nascentia Health Options and paid for by any other insurance you may have.

Your Care Manager and Member Service Representatives are very valuable resources for you and your caregivers. Contact them at 888-4777-HOME (4663) for any questions or information.

MEMBER RIGHTS AND RESPONSIBILITIES

Your Rights

As a member of Nascentia Health Options you have a 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 get oral translation services free of charge;
- get information necessary 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;
- 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;
- be told where, when and how to get the services you need from your managed long term care; plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network;
- 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; and
- appoint someone to speak for you about your care and treatment.
- Seek assistance from the Participant Ombudsman program
- Make advance directives and plans about your care

Your Responsibilities

As a member of Nascentia Health Options you agree to:

- work with your Care Manager to become as independent and self-managing as possible;
- find out how your health care system works;
- listen to your health care provider's advice and ask questions when you are in doubt;
- treat health care staff with the respect you expect yourself;
- tell us if you have problems with any health care staff;
- keep your appointments. If you must cancel, call as soon as you can.;
- use the emergency room only for real emergencies;
- call your health care providers when you need medical care, even if it is after-hours;
- use Providers who work with Nascentia Health Options for covered services;
- Receive all your covered services from the Nascentia Health Options Provider Network
- get approval from your Care Manager before getting covered service;
- contact your Care Manager any time you use the emergency room, are hospitalized, get new prescriptions or receive a referral to another medical provider; and
- if you have a spenddown (surplus) to be Medicaid eligible, you must pay this to Nascentia Health Options. (See Spenddown section)
- tell us when you plan to be out of town so we can help you arrange services
- tell us when you believe there is a need to change your person-centered service plan

We encourage you to participate in the policy development of the organization. If at any time you believe that you have a suggestion for improving the services Nascentia Health Options provides, please call or write to: Insert address

Nascentia Health Options
1050 West Genesee St
Syracuse, NY 13204
Attn: Member Services
We value member opinions and would appreciate any comments that you have

PART II YOUR BENEFITS AND PLAN PROCEDURES

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

BENEFITS

Medicaid managed long term care provides a number of services you get in addition to those you get with regular Medicaid. Nascentia Health Options will provide or arrange for most home and community based services that you will need.

You will continue to see your Primary Care Provider (PCP) and any specialty care providers, obtain your medications and prescription refills through your pharmacy, obtain X-Rays and other radiology services, receive emergency transportation, inpatient and outpatient hospital and clinic services as you did before joining Homecare Options, LLC.

SERVICES COVERED BY NASCENTIA HEALTH OPTIONS

You must get these services from the providers who are in Nascentia Health Options provider network. All services must be medically necessary and provided or referred by your Care Manager. Nascentia Health Options has arrangements with several providers for the services below. As a member of Nascentia Health Options you must use one of the network providers for the following services:

- Care Management including Home Delivered or Congregate Meals, Social Day Care and social and environmental Supports
- Nursing Home Care (Residential health Care Facility) Home Care, including Nursing, Home Health Aide, Occupational, Physical, Speech Therapies and Medical Social Services
- Adult Day Health Care
- Personal Care
- DME including Medical/Surgical Supplies, enteral and Parenteral Formula, and hearing aid batteries
- Prosthetic, Orthotics and Orthopedic Footwear
- Personal Emergency Response System
- Non-emergency transportation to receive medically necessary services
- Podiatry (foot care)
- Dental Services
- Optometry/Eyeglasses -
- PT, OT, SP or other therapies provided in a setting other than a home. Limited to 20 visits each therapy type per calendar year, except for children under 21 and the developmentally disabled we may authorize additional visits
- Audiology/Hearing Aids
- Respiratory Therapy
- Nutrition
- Private Duty Nursing
- Rehabilitation Therapies
- Consumer Directed Personal Assistance Program

- Telehealth

Should your provider decide to leave Nascentia Health Options network and you are in an ongoing course of treatment, you may continue with that provider as we transition you to another within our network. Your care with that provider will continue for up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Person Centered Service Planning and Care Management
Upon enrollment, you will be assigned a Care Manager who will assist you to access necessary covered services as identified in your person-centered service plan. (PCSP) It also provides referral and coordination of other services in support of your PCSP Care management services will assist you to obtain needed medical, social, educational, psychosocial, financial and other services in support of the PCSP even if the needed services are not covered under Nascentia Health Options.

Home Care Services (Nursing, Therapy, Home Health Aide and Personal Care)
Home care is one of the key components to maintaining you in your home and community. Your Care Manager will assess your home care needs and determine the frequency that you will require these services. They will authorize the amount of service that is determined to meet your medical and personal care needs. Home care includes the following services which are of a preventive, therapeutic rehabilitative, health guidance and/or supportive nature: nursing services, home health aide services, nutritional services, social work services, physical therapy, occupational therapy and speech/language pathology.

Nursing Services
Include intermittent, part-time and continuous nursing services provided in accordance with an ordering physician's treatment plan as outlined in the physician's recommendation. Nursing services must be provided by RNs and LPNs in accordance with the Nurse Practice Act. Nursing services include care rendered directly to the individual and instructions to his family or caretaker in the procedures necessary for the patient's treatment or maintenance.

Physical Therapy (PT)
Rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Physical therapy services provided in home and community based settings.

Occupational Therapy (OT)
Rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Occupational Therapy services provided in home and community based settings.

Speech-Language Pathology (SP)
A licensed and registered speech-language pathologist provides rehabilitation services for the purpose of maximum reduction of physical or mental disability and restoration of the Enrollee to his or her best functional level. Speech Pathology services provided in home and community based settings. PT< OT SP and other therapies provided in a setting outside the home are limited to 20 visits of each therapy type per calendar year.

Respiratory Therapy
A licensed and registered Respiratory Therapist will perform preventive, maintenance and rehabilitative airway-related techniques and procedures including the application of medical gases, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation and related airway management, patient care, instruction of patients and provision of consultation to other health personnel.

Medical Social Services
Social workers will provide information, make referrals, and assist with obtaining or maintaining benefits which include financial assistance, medical assistance, food stamps, or other support programs provided by the LDSS, Social Security Administration, and other sources. Social services also involve providing supports and addressing problems in your living environment and daily activities to assist you in remaining in the community. These services will be provided by a qualified social worker as defined in NYS regulations.

Private Duty Nursing
Medically necessary services provided at your permanent or temporary place of residence, by a licensed registered professional or licensed practical nurses (RNs or LPNs) in accordance with physician orders. These services may be continuous and may go beyond the scope of care available from certified Home Health Agencies (CHHAs). Should you require continuous and skilled nursing care provided in your home, we will arrange for properly licensed registered professional or licensed practical nurses to provide that care.

Home Health Aide
A person who carries out health care tasks under the supervision of a registered nurse or licensed therapist and who may also provide assistance with personal hygiene, housekeeping and other related supportive tasks to an Enrollee with health care needs in his home.

Personal Care Aide
A person who provides some/total assistance with such activities as personal hygiene, dressing, feeding and nutritional and environmental support functions. Personal care must be medically necessary, ordered by the Enrollee's physician and provided by a person qualified under NYS regulations in accordance with a PCSP.

Consumer Directed Personal Assistance Program (CDPAP)

The purpose of the Consumer Directed Personal Assistance Program is to permit chronically ill or physically disabled individuals receiving home care services under the medical assistance program greater flexibility and freedom of choice in obtaining such services. Assistance is provided for 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 a member or the member's designated representative.

A Personal Assistant is an adult who provides consumer directed personal assistance to a member under the member's instruction, supervision and direction or under the instruction, supervision and direction of the member's designated representative. A member's spouse, parent or designated representative may not be the consumer directed personal assistant for that member; however, a consumer directed personal assistant may include any other adult relative of the member who does not reside with the member or any other adult relative who resides with the member because the amount of care the member requires makes such relative's presence necessary.

The plan must assess whether the individual is eligible for the program. The assessment process includes a physician's order, a social assessment and a nursing assessment to determine if this is the appropriate level of assistance.

Responsibility of the Health Plan in Consumer Directed Personal Assistance

The Health Plan will:

- Provide the member requesting personal care services with information about how to qualify for CDPAS and other community based long term care services.
- Provide the member with written educational materials outlining the roles and responsibilities for the member/designated representative if member expresses an interest in CDPAP.
- Assess whether the member is eligible to receive home care or personal care services.
- Determine if the member is able and willing to assume all responsibilities associated with receiving the service, or has a designated representative or other identified adult, able and willing to act on the member’s behalf.
- Determine whether member is eligible to receive CDPAP.
- Assess and document the member’s health patient centered care plan to assure adequate supports are available to meet the member’s needs.
- Authorize the type, amount and level of services required by the member.
- Develop a PCSP with the member, outlining the tasks to be completed by the personal assistant. The PCSP document will be maintained with the Plan and a copy will be provided to the member.
- If it is determined that the member is no longer eligible to continue receiving CDPAS, or Plan terminates the member’s receipt of CDPAP the Plan will assess on an ongoing basis whether the member requires personal care, home health care or some other level of service.
- Provide the member with appropriate notices including a notice of fair hearing for restriction, reduction, suspension or termination of the level and amount of services or determining that the member is not eligible or no longer eligible to receive CDPAS.

Responsibilities of the Member with Consumer Directed Personal Assistance

The Member/Designated Representative (Member) will:

- Review the information provided by the Plan about CDPAP and understand the roles and responsibilities of the Plan, the fiscal intermediary and the Member.
- Be responsible for recruiting, hiring, and training, supervising, scheduling and terminating the personal assistant(s) of the member's choosing in adequate numbers to meet the needs of the member.
- Maintain an appropriate home environment for the safe delivery of care required by the member.
- Train the personal assistant(s) to implement the PCSP.
- Comply with labor laws, providing equal employment opportunities as specified in the agreement between Member and the Fiscal Intermediary (FI).
- Inform the Plan and the FI of any change in status or condition including but not limited to: hospitalizations, address and telephone number changes, vacations within 5 business days.
- Assure the accurate and timely submission of the personal assistant's required paper work to the FI including time sheets, annual worker health assessments, and required employment documents.
- Develop and maintain a contingency plan to assure adequate supports are available to meet the member's needs.
- Review and sign the personal assistant's timecards assuring that the hours reflect the actual number of hours worked within the weekly authorized hours.
- Cooperate with the Plan and agree to comply with Medicaid Managed Care Program requirements including but not limited to availability for required reassessments.
- Report and return to MCO any overpayment or inappropriate payments from the Medicaid program made to Consumer Directed Personal Assistants.

Dental Care

We believe that providing you with good dental care is important to your overall health. We offer dental care through Healthplex as indicated in the provider network section. Covered **Dentistry** services includes but shall not be limited to preventive, prophylactic and other dental care, services and supplies, routine exams, prophylaxis, oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition including one which affects employability.

How to Access Dental Services:

Dental services are administered through Healthplex who has a large network of dental providers that can meet your personal needs.

To find a dentist in your area, call 1-800-468-9868 or TTY/TDD 1-800-662-1220 and tell them you are a member of Nascentia Health Options. The operator will give you a list of dentists near you that you can choose from.

For further assistance in arranging dental services you can contact your Care Manager and they will help you schedule an appointment.

Make sure you bring your Member ID card with you to your appointment so the dentist can bill us.

Vision Care
Maintaining healthy eyes and vision is an important aspect of our member's health. Routine eye exams are covered every 2 years unless medically needed more often. **Optometry** includes the services of an optometrist and an ophthalmic dispenser, and includes eyeglasses; medical necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) 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 Enrollee's condition. Examinations which include refraction are limited to every two years unless otherwise justified as medically necessary. Glasses, frames and lenses are provided every 2 years or more often if medically needed. Coverage also includes the repair or replacement of parts in situations where the damage is the result of causes other than defective workmanship. Replacement parts will duplicate the original prescription and frames. Repairs to and replacement of frames and/or lenses must be provided as needed. We offer vision care through contracts with those listed in our provider network section.

How to Access Vision Care Services:
Contact your Care Manager for authorization and make an appointment with one of our Network Providers. Should you need assistance in arranging for vision care, your Care Manager can assist you in making an appointment. When you visit the optometrist, show your Member ID care to access your vision benefit.

Social & Environmental Supports
Services and items that support the medical needs of the members 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. Your Care Manager will help arrange these services if you require them.

Residential Health Care Facility Care (Nursing Home)
Our goal is to maintain you in your own home in the community. At times, when ordered by your physician and authorized by Nascentia Health Options, nursing home care may be required for a short time after a hospital stay. Your Care Manager will work with the licensed facility to develop a plan for rehabilitation and a quick return to your home. The plan also covers permanent nursing home placement but the member must be eligible for Institutional Medicaid coverage.

Non-Emergency Transportation
Nascentia Health Options covers non-emergency medical transportation. Transportation by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the Enrollee's condition for the Enrollee to obtain necessary medical care and services. You can contact Member Services to arrange for transportation at 888-477-HOME (4663) If you require an attendant or special transportation arrangement, please make member services aware of your special need. If you have questions about transportation, please call Member Services at 888-477-HOME (4663).

Transportation requests must be made 72 hour in advance. Requests for same day transport will be accommodated when possible but there is no guarantee that the transportation vendor will be able to accommodate the request on such short notice.

Durable Medical Equipment (DME) / Hearing Aids / Prosthetics /Orthotics
If you require medical equipment or devices, your PCP in collaboration with your Care Manager and other members of the interdisciplinary team will make arrangements for you to obtain these items. DME includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula* and hearing aid batteries. Durable medical equipment are devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics:

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

Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances and devices, durable medical equipment or orthopedic footwear which treat a specific medical condition and which are usually consumable, non-reusable, disposable, for a specific purpose and generally have no salvageable value. If you have questions or believe you may need certain equipment contact your Care Manager at 888-477-HOME (4663)

*Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism

Prosthetics are appliances and devices, which replace any missing part of the body.

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

Orthopedic footwear are shoes, shoe modifications or shoe additions which are used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot; to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace. * Prescription footwear and inserts are limited to use in conjunction with a lower limb orthotic brace, as part of a diabetic treatment plan.

Podiatry
For those Members that require podiatry services for routine foot care when your physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, or when they are performed as necessary and integral part of medical care such as the diagnosis and treatment of diabetes, ulcers, and infections will be authorized by your Care Manager. We offer podiatry care through contracts with those listed in our provider network section. Members with diabetes may require more frequent foot care. Your Care Manager will assist in the authorization and coordination of that care. Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of pathological condition.

Audiology/ Hearing Aids
Nascentia Health Options will arrange for hearing evaluations for those Members that are having hearing difficulties. 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. If you require a hearing aid your Care Manager will assist in the authorization of the hearing aid.

Adult Day Health and Social Day Care Programs
Your Care Manager in conjunction with your PCP and interdisciplinary team may determine that attendance at one of these day programs is a compliment to your other home and community based services. 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, dental pharmaceutical, and other ancillary services.

Social Day Care
A structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance. Your Care Manager will authorize the program and frequency of attendance based on your medical and functional status.

Emergency Response System
You may be at risk for falls or require rapid response from an emergency. The Emergency Response System is an electronic device which enables certain high-risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems now exist which employ different signaling devices. Such systems are usually connected to a patient's phone and signal a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center. Your Care Manager will discuss with you if this service is right for you.

Nutrition & Meals
A qualified nutritionist can provide an assessment of nutritional needs and food patterns, the planning for the provision of foods and drink appropriate for your physical and medical needs, or the provision of nutrition education and counseling. In addition, these services may include the assessment of nutritional status and food preferences, planning for provision of appropriate dietary intake, nutritional education regarding therapeutic diets, and development of a nutritional treatment plan,

Home-delivered or congregate meals may be authorized by Nascentia Health Options Care Manager when this service is required to meet your medical, functional and nutritional needs.

Telehealth Services
Telehealth delivered services use electronic information and communication for telehealth providers to deliver health care services, which include the clinical discipline assessment, diagnoses consultation, treatment, education, care management and/or self-management of an Enrollee. The contractor is responsible for covering services in the benefit package that are delivered by telehealth in accordance with Section 2999-cc of the Public Health Law.

Hospice Services
Hospice services provide appropriate skilled, compassionate care to patients and their families so that they receive the support, help and guidance they need to meet the challenges of serious illness. It focuses on comfort, emphasizes quality of life and promotes personal choice and individual dignity. Hospice services are available to enrollees who meet hospice eligibility requirements and are not enrolled in Hospice services prior to their enrollment into our plan.

Veterans Home Services
If you are a veteran, spouse of a veteran or Gold Star parent member in need of long term placement, and desire to receive care from a veteran's home, we will assist you in accessing and receiving veteran's home services.

Covered Services Outside Service Area
There may be a time when you are out of the area but require covered services. Contact Member Services toll free at **888-477 HOME (4663)** to discuss your needs.

The following services are not covered by Nascentia Health Options but are covered by your Medicare and Medicaid on a fee-for-service basis. You will continue to use your Medicare and Medicaid benefit card to receive these services.

- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Laboratory Services
- Radiology and Radioisotope Services
- Emergency Transportation
- Rural Health Clinic Services
- Chronic Renal Dialysis
- Mental Health Services
- Alcohol and substance Abuse services
- Office for People with Developmental Disabilities Services
- Family Planning Services
- Prescription and Non-Prescription Drugs and Compounded prescriptions

Members have the right to choose providers for Nascentia Health Optionscovered services paid for by Medicare. However, when Medicare stops paying for these services, the member must use a network provider in order for Nascentia Health Options to cover the service. Nascentia Health Options pays the Medicare co-pay for covered services if Medicare is the primary payer.
Although these services are not part of the Nascentia Health Options benefit package, your Care Manager will help arrange and coordinate them as needed.

Physicians & Outpatient Clinics
You will continue to get your primary health care from your physician and clinics that you have been using. You do not need to get authorization to see your physician or attend a clinic. Your Nascentia Health Options Care Manager will be obtaining orders from your PCP and coordinating care with them.

Prescription & Non-Prescription Drugs
You can get prescriptions, over-the-counter medicines, and some medical supplies from any pharmacy that takes Medicaid. A limited enteral formula benefit is included as a plan benefit. A co-payment may be required for some people, for some medications and pharmacy items.

Certain medications may require that your doctor get prior authorization from Medicaid before writing your prescription. Getting prior authorization is a simple process for your doctor and does not prevent you from getting medications that you need.

Medicare Part D is a prescription drug benefit available to everyone with Medicare. It has special importance to people with Medicare *and* New York State Medicaid because **Medicare Part D replaces Medicaid in paying for most of your prescription drugs**

Under the Medicare Part D prescription benefit almost all of your drugs costs will be paid for by **Medicare** *instead of* Medicaid. You will get prescription drug coverage from Medicare and pay a small Medicare copayment for each prescription. If you currently receive NYS Medicaid and you do not join a Medicare prescription drug plan, you may lose all your NYS Medicaid benefits.

When you become eligible for both Medicare and Medicaid you will automatically be assigned to a Medicare Prescription Drug Plan to make sure you don't miss a day of coverage. You can also enroll in a plan of your own choosing that may better meet your prescription drug needs. Information about available plans and the “Medicare & You” handbook is available from Medicare. Be sure to read this information to understand all the changes.

Emergency Transportation
Should you require transportation for a medical emergency to the hospital, you will continue to access this as you have. Contacting 911 in a true medical emergency is an appropriate action.

SERVICES NOT COVERED BY NASCENTIA HEALTH OPTIONS OR MEDICAID

You must pay for services that are not covered by Nascentia Health Options 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 Nascentia Health Options or Medicaid are:

- Cosmetic surgery if not medically needed
- Routine foot care (for those 18 years and older)
- Personal and comfort items
- Infertility Treatment
- Services for which you need a referral (approval) in advance and you did not get it.

If you have any questions, call Member Services at 888-477 HOME (4663)

Spenddown

Some enrollees will be eligible for Medicaid by paying a spenddown. Your spenddown amount is determined by the Local Department of Social Services. If you have a spenddown (surplus) to be Medicaid eligible, you must pay this to Nascentia Health Options. Failure to pay your spenddown may result in loss of Medicaid eligibility and involuntary disenrollment from Nascentia Health Options.

Please send Spenddown payments to: Nascentia Health Options
1050 W Genesee St. Ste 2
Syracuse, NY 13204-9900

Nascentia Health Options may initiate Involuntary Disenrollment if a member fails to pay any amount owed as a Medicaid spenddown/surplus within 30 day after such amount becomes due. We will make reasonable efforts to collect the surplus, including written demand for payment and advising the member of his/her prospective disenrollment.

Emergencies

You are always covered for emergencies. An emergency means a medical or behavioral condition:

- that comes on all of a sudden; and
- has pain or other symptoms.

This would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away. Examples of an emergency are:

- a heart attack or severe chest pain
- bleeding that won't stop or a bad burn
- broken bones
- trouble breathing, convulsions, or loss of consciousness
- when you feel you might hurt yourself or others
- if you are pregnant and have signs like pain, bleeding, fever, or vomiting

If you have an emergency, here's what to do:

If you believe you have an **emergency**, call 911 or go to the emergency room or urgent care.

You do not need prior approval for emergency services. Use the emergency room only if you have an emergency.

The Emergency Room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your primary care physician or Nascentia Health Options at 888-477-HOME (4663) at any time.

If you're not sure, call your primary care physician or Nascentia Health Options.

Tell the person you speak with what is happening. Your primary care physician or member services representative will:

- tell you what to do at home,
- tell you to come to the PCP's office, or
- tell you to go to the nearest emergency room.

If you are **out of the area** when you have an emergency, go to the nearest emergency room.

Care Planning

Person Centered Service Plan (PCSP)

When you enroll, you, your physician, and your Care Management Team will work together to develop a PCSP that meets your needs. Your PCSP will include all of the services you need to maintain and improve your health status. The plan of care includes both Nascentia Health Options covered services and those services covered by Medicaid and Medicare. It is based on our assessment of your health care needs, the recommendation of your physicians and your personal preferences.

As your health care needs change you may require different services or the same services more or less frequently. Naturally this will require that your PCSP changes. Your Care Management Team and your physician will review and approve any changes to your PCSP. They will periodically evaluate it with you to ensure that the services you are receiving meet your needs. Generally, a PCSP is assessed and authorized at six month intervals or more frequently if necessary. It will be adjusted as your medical needs increase or decrease.

You are an important member of your health care team so it is important for you to let us know what you need. Please talk with your physician and Care Management Team if you have a need for any service you are not currently receiving or wish to make changes in your plan of care. In addition, your Care Management Team will work with you to make certain that your medical conditions are being properly monitored.

SERVICE AUTHORIZATION & ACTIONS

Prior Authorization

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Home Care, including Nursing, Home Health Aide, Occupational, Physical and Speech Therapies
- Audiology/Hearing Aids
- Dental Care (except for routine preventative care every 6 months)
- Vision Care (except for routine eye exam and glasses every 2 years)
- Respiratory Therapy
- Nutrition
- Medical Social Services
- Personal Care (such as assistance with bathing, eating, dressing, etc.)
- Podiatry (foot care)
- Non-emergency transportation to receive medically necessary services
- Home Delivered and/or meals in a group setting (such as a day center)
- Medical Equipment
- Social Day Care
- Prostheses and Orthotics
- Social/Environmental Supports (such as chore services or home modifications)
- Personal Emergency Response System
- Adult Day Health Care
- Nursing Home Care

Asking for approval of a treatment or service is called a **service authorization request**. To get approval for these treatments or services please do the following:

You or your primary care provider may contact Member Services at 888-477-HOME (4663) for authorization for these services.

You will also need to get prior authorization if you are getting one of these services now, but need to continue or get more of the service. This includes a request for home health care while you are in the hospital or after you have just left the hospital. This is called **concurrent review**.

What Happens After We Get Your Service Authorization Request

Nascentia Health Options has a review team to make sure you get the services we promise. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your care plan against medically acceptable standards.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, this could be a doctor or may be a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track/expedited** process. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your case will be handled under the standard review process. If you are in the hospital or have just left the hospital and we receive a request for home health care, we will handle the request as a fast track review. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than mentioned below.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don't agree with our decision.

Timeframes for Prior Authorization Requests

Standard review: We will make a decision about your request within 3 business days of when we have all the information we need, but no more than 14 days after we receive your request. We will tell you by the 14th day if we need more information.

Fast track/ expedited review: We will make a decision and you will hear from us within 3 business days after receipt of the request We will tell you by the third business day if we need more information.

Timeframes for Concurrent Review Requests

Standard review: We will make a decision within 1 business day after receipt of necessary, but no more than 14 days after we received your request. We will tell you by the 14th day if we need more information.

Fast track/ expedited review: We will make a decision within 1 business day after receipt of necessary information but no more than 3 business days of receipt of the request. In the case of a request for Medicaid covered home health care services following an inpatient admission, one (1) business day after receipt of necessary information; except when the day subsequent to the Service Authorization Request falls on a weekend or holiday, then seventy-two (72) hours after receipt of necessary information; but in any event, no more than three (3) business days after receipt of the Service Authorization request.

If we need more information to make either a standard or fast track decision about your service request we will:

- Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling toll free at 888-477-HOME (4663) or writing to Nascentia Health Options, 1050 West Genesee Street, Syracuse, New York 13204.

You or someone you trust can file a complaint with the plan if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you are not satisfied with this answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

Other Decisions about Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called **retrospective review**. We will tell you if we take these other actions.

Timeframes for Notice of Other Actions

In most cases, if we make a decision to restrict, reduce, suspend or terminate a service we have already approved and you are now getting, we must provide you written notice at least ten (10) days prior to the effective date we change the service.

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 Nascentia Health Options (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 the plan speed up/expedite the review of the 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 any information that must be provided by you and/or your provider in order for Nascentia Health Options to render a decision on appeal.

If Nascentia Health Options is restricting, reducing, suspending or terminating an authorized service, the notice will also explain a member's right to have services continue while Nascentia Health Options decides the appeal; how to request that services be continued; and the circumstances under which the member might have to pay for services if they are continued while Nascentia Health Options reviewed the appeal.

If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

ACTION APPEALS

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called **prior authorization**. Asking for approval of a treatment or service is called a **service authorization request**. This process is described earlier in this handbook. Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an **action**.

If you are not satisfied with our decision about your care, there are steps you can take.

Your provider can ask for reconsideration
If we made a decision that your service authorization request was not medically necessary; your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one work day.

You can file an action appeal
If you are not satisfied with an action we took or what we decide about your service authorization request, you have 60 business days after hearing from us to file an action appeal.

You can do this yourself or ask someone you trust to file the action appeal for you. You can call Member Services 888-477-HOME (4663) if you need help filing an action appeal.

We will not treat you any differently because you file an action appeal.
• The action appeal can be made by phone or in writing. If you make an action appeal by phone, it must be followed up in writing.

Your Action Appeal Will Be Reviewed Under the Expedited Process

- If you or your doctor asks to have your action appeal reviewed under the expedited process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your action appeal will be reviewed under the standard process;
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided;
- If your request was denied when you asked for home health care after you were in the hospital.

Expedited action appeals can be made by phone and do not have to be followed up in writing.

What Happens After We Get Your Action Appeal

- Within 15 days, we will send you a letter to let you know we are working on your action appeal.
- Action appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.

- Before and during the action appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case;
- You can also provide information to be used in making the decision in person or in writing. Call Nascentia Health Options at 888-477-HOME (4663) if you are not sure what information to give us.

If you are appealing our decision that the out-of-network service you asked for was not different from a service that is available in our network, ask your doctor to send us the following:

- a written statement that the service you asked for is different from the service we have in our network; and
- two pieces of medical evidence (published articles or scientific studies) that show the service you asked for is better for you, and will not cause you more harm than the service we have in our network.

You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, any further appeal rights you have will be explained or you or someone you trust can file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Action Appeals

Standard action appeals: If we have all the information we need we will tell you our decision in thirty days from your action appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

Fast track/ Expedited action appeals: If we have all the information we need, fast track action appeal decisions will be made in 2 work days from your action appeal. We will tell you in 3 work days after giving us your action appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we need more information to make either a standard or fast track decision about your action appeal we will:

- Write you and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest
- Make a decision no later than 14 days from the day we asked for more information

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 888-477-HOME (4663) or writing.

You or someone your trust can file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1.800.206.8125.

If your original denial was because we said:

- the service was not medically necessary; or
- the service was experimental or investigational; or

- the out-of-network service was not different from a service that is available in our network; and
- we do not tell you our decision about your action appeal on time, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue While Appealing a Decision About Your Care

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:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur and the original period covered by the service authorization has not expired. Services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after Nascentia Health Options mails your notice about the appeal decision, if the decision was not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services.

If your fair hearing results in another denial you may have to pay for the cost of any continued benefits that you received. The decision you receive from the fair hearing officer will be final.

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.

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.

GRIEVANCE and Appeal PROCESS

Grievance and Appeal Process

Nascentia Health Options 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 Nascentia Health Options staff or a health care provider because you filed 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: 1-888-477- HOME (4663) or write to:

Nascentia Health Options
1050 West Genesee St
Syracuse, NY 13204
Attn: Appeals and Grievances Department

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 time frames.

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 Nascentia Health Options restricts, 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, (See How do I File an Appeal of an Action?

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 1-888-477-HOME (4663) or writing to:

Nascentia Health Options
1050 West Genesee St
Syracuse, NY13204
Attn: Appeal and Grievances Department

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal and how we will handle it. Your

appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

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.

(See Fair Hearing Section)

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

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.

FAIR HEARINGS

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

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

1. By phone, call toll-free 1.800.342.3334
2. Emergency Fair Hearing Line: 1 (800) 205-0110
3. TTY line 711 (request that the operator call 1 (877) 502-6155
4. By fax, 518.473.6735
5. By internet, www.otda.state.ny.gov/hearings/request/
6. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings, Managed Care Hearing Unit P.O. Box 22023, Albany, NY 12201
7. Request in Person:

New York City	Albany
14 Boerum Place, 1st Floor	40 North Pearl St, 15th Floor
Brooklyn, NY 11201	Albany, NY 12243

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 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, you must file the form with the New York State Department of Financial Service 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. This 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 will lose your right to an external appeal if you do not file an application for an external appeal on time.

To ask for an external appeal, fill out an application and send it to the State Department of Financial Services. You can call Member Services at 888-477-HOME (4663) if you need help filing an appeal. You and your doctors will have to give information about your medical problem. The external appeal application says what information will be needed.

Here are some ways to get an application:

- Call the State Department of Financial Services 1.800.400.8882
- Go to the State Department of Financial Services website at www.dsf.state.ny.us
- Contact the health plan 1.888.477.4663
-

HOW OUR PROVIDERS ARE PAID

You have the right to ask us whether we have any special financial arrangement with our providers that might affect your use of health care services. You can call Member Services at 888-477-HOME (4663) if you have specific concerns. We also want you to know that most of our providers are paid the following way.

Our Providers are paid by **fee-for-service.** This means they get a plan-agreed-upon fee for each service they provide.

YOU CAN HELP WITH PLAN POLICIES

We value your ideas. You can help us develop policies that best serve our members.

If you have ideas tell us about them. Maybe you'd like to work with one of our member advisory boards or committees. Call Member Services at 888. 477.HOME (4663) to find out how you can help.

INFORMATION FROM MEMBER SERVICES

You can get the following information by calling Member Services at 888. 477.HOME (4663):

- A list of names, addresses, and titles of Nascentia Health Options Board of Directors, Officers, Controlling Parties, Owners and Partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the State Department of Financial Services about consumer complaints about Nascentia Health Options
- How we keep your medical records and member information private
- In writing, we will tell you how Nascentia Health Options checks on the quality of care to our members
- We will tell you which hospitals our health providers work with
- We will tell you the guidelines we use to review conditions or diseases that are covered by Nascentia Health Options
- We will tell you the qualifications needed and how health care providers can apply to be part of Nascentia Health Options
- Information about how our company is organized and how it works

KEEP US INFORMED

Call Member Services whenever any of the following changes happen in your life:

- You change your name, address or telephone number
- You have a change in Medicaid eligibility

DISENROLLMENT AND TRANSFERS

You can ask to leave the Nascentia Health Options at any time for any reason.

To Disenroll or Change Plans

Call your Care Manager to start the disenrollment process. It will take between two and six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another managed long term care plan as long as you qualify.

While you are in the process of disenrollment, Nascentia Health Options will continue to provide your covered services until the disenrollment date.

You must leave Nascentia Health Options if you:

- Permanently move out of the County or service area
- Are out of the plan's service area for more than 30 consecutive days.
- Need nursing home care but are not eligible for institutional Medicaid
- Are no longer eligible to receive Medicaid benefits
- Enroll in another managed long term care plan,
- Are hospitalized for 45 days or longer
- You clinically require nursing home care but is not eligible for such care uner the Medicaid Programs institutional rules
- Join a Home and Community Based Services Waiver program or enroll in a program or become a resident in a facility under the auspices of the Office of Mental Health, Office for People with Developmental Disabilities or Office of Alcohol and Substance Abuse Services
- Are no longer eligible for MLTC as determined at the last comprehensive assessment as no longer demonstrating a functional or clinical need for community based long term care services, or for non-dual eligible members, in addition no longer meets the nursing home level of care as determined using the assessment tool prescribed by the Department, unless the plan and the State agree that termination of services could reasonably be expected to result in the member being eligible for nursing home level of care; or
- Are incarcerated

We Can Ask You to Leave Nascentia Health Options

You may be disenrolled from Nascentia Health Options if:

- You, a family member or another person in the home behaves in a way that prevents Nascentia Health Options from providing the care you need;
- You knowingly provide false information or behave in a deceptive or fraudulent way;
- You or your family member fails to complete or submit any consent form or other document that is needed to obtain services for you

- Your physician refuses to work with Nascentia Health Options in developing and implementing a plan of care for you;
- You fail to pay or make efforts to pay money owed to Nascentia Health Options (spenddown/surplus)

ADVANCE DIRECTIVES

There may come a time when you can't decide about your own health care. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, healthcare providers, your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Health Care Proxy
With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

CPR and DNR
You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

Organ Donor Card
This wallet sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

IMPORTANT PHONE NUMBERS

Your Primary Care Physician	_____
Nascentia Health Options	888.477.4663
Member Services	888-477-HOME (4663)
Member Services TTY/TDD	711
Utilization Review	Toll Free 1- 888-477-HOME
(4663)	
New York State Department of Health (Complaints)	1-866-712-7197
County Department of Social Services	_____
Other Health Providers	_____

Nascentia Health Options Nondiscrimination Notice

Nascentia Health Options complies with Federal civil rights laws. VNA Home Homecare does not exclude people or treat them differently because of race, color, national origin, disability, disability or sex.

Nascentia Health Options provides the following:

- Free aids and services to people with disabilities to help communicate with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, call Nascentia Health Options at 1-888-477-HOME (4663). For TTY/TDD services, call 711.

If you believe that Nascentia Health Options has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Nascentia Health Options by:

- Call 1-877-HOME (4663)). TTY users should call: 711
- Send a fax to 1-844-530-3676.
- Send a letter to:

- Nascentia Health Options
- 1050 West Genesee St
- Syracuse, NY 13204

You can also file a civil rights complaint with the U.S. Department of Health and Human services, Office for Civil Rights by:

- Web: Office for Civil rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

- Mail: U.S. department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201

  Complaint forms available at: http://www.hhs.gov/ocr/office/file/index.html

- Phone: 1-800-868-1019 (TTY/TDD 800-537-7697

LANGUAGE ASSISTANCE

ATTENTION: Language Assistance services, free of charge, are available to you. Call toll free 1-888-477-4663. TTY/TDD call 711	English
ATENCIÓN: sihablaespañol, tiene a sudisposiciónserviciosgratuitos de asistencialingüística. Llame al 1-888-477-4663. TTY/TDD call 711	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-477-4663. TTY/TDD call 711	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-477-4663 (رقم (711). والبكم الصم:	Arabic
주의: 한국어를□□□□□□□, □□□□□□□□□□□□□□□□□□□□. 1-888-477-4663(TTY: 711)□□□□□□주십시오	Korean
ВНИМАНИЕ: Еслывыговоритенарусскомязыке, товамдоступныбесплатныеуслугиперевода. Звоните 1-88-477-4663 (телетайп: 711)	Russian
ATTENZIONE: In caso la lingua parlatasial'italiano, sonodisponibiliservizi di assistenzalinguisticagratuiti. Chiamareilnumero 1-888-477-4663 (TTY: 711).	Italian
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-477-4663 (ATS: 711)	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1- 888-477-4663 (TTY: 711)	French Creole
אויפמערקזאם: פריי סערוויסעס הילף שפראך אייך פאר פארהאן זענען, אידיש רעדט איר אויב 1-888-477-4663 (TTY: 711). רופט אפצאל פון	Yiddish

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-477-4663. TTY: 711	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-477-4663 (TTY: 711)	Tagalog
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KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-477-4663 (TTY: 711)	Albanian
ΠΡΟΣΟΧΗ:Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν.Καλέστε 1888-477-4663 TTY 711	Greek
خبردار: وبودارآپالکںیہاںتسدںیمتفمامدخیکددمںیکانبزوکوآپوت،ںیہےتل 1-888-477-4663 (TTY: 711). ک	Urdu

1050 West Genesee Street, Syracuse, NY 13204
1.888.477.HOME (4663)