

WELCOME TO THE SENIOR WHOLE HEALTH PLUS OF NEW YORK MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to Senior Whole Health Plus of New York Medicaid Advantage Plus Program. The Medicaid Advantage Plus Program is especially designed for people 65 and older who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits Senior Whole Health Plus of New York covers since you are enrolled in the Senior Whole Health Plus of New York Medicaid Advantage Plus Program. It also tells you how to request a service, file a complaint or grievance or disenroll from Senior Whole Health Plus of New York Medicaid Advantage Plus Program. The benefits described in this handbook are in addition to the Medicare benefits described in the Senior Whole Health Plus of New York Medicare Evidence of Coverage. Keep this handbook with the Senior Whole Health Plus of New York Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM MEMBER SERVICES

You can call us at anytime at the Member Services number below. There is someone to help you at Member Services: Monday through Friday, 8a.m. to 8p.m., and also on Saturdays and Sundays from November 1st to March 15th. If you may also call if you need medical help during non-business hours, on weekends or holidays.

Call 1-866-211-1777/TTY 1-866-404-9507 (toll free)

ELIGIBILITY FOR ENROLLMENT IN THE MEDICAID ADVANTAGE PLUS PROGRAM

Senior Whole Health Plus of New York Medicaid Advantage Plus is for people who have both Medicare and Medicaid. You are eligible to join the Medicaid Advantage Plus Program if you are also enrolled in Senior Whole Health Plus of New York for Medicare coverage and:

- 1) Are aged **65** and older;
- 2) Reside in the Senior Whole Health service area, which includes: Albany, Columbia, Dutchess, Greene, Montgomery, Orange, Rensselaer, Saratoga, Schenectady, Ulster, Warren, and Washington counties.
- 3) Have a chronic illness of disability that makes you eligible for services usually provided in a nursing home;
- 4) Are able to stay safely at home at the time you join our plan and
- 5) Are expected to need one or more of the following services for at least 120 days from the date that you join our plan:
 - a. Nursing services in the home
 - b. Therapies in the home
 - c. Home health aide services
 - d. Personal care services in the home
 - e. Adult day health care, or
 - f. Social day care if used instead of in-home personal care services.

SWH Member Services 1-866-211-1777 / TTY 1-866-404-9507

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in Senior Whole Health Plus of New York Medicaid Advantage Plus. Enrollment in the Medicaid Advantage Plus Program is voluntary.

SERVICES COVERED BY THE SENIOR WHOLE HEALTH MEDICAID ADVANTAGE PLUS PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the Senior Whole Health Plus of New York Medicare Evidence of Coverage. Sections 2 and 3 of Senior Whole Health Plus of New York Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of Senior Whole Health Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined Senior Whole Health Plus of New York, and you have Medicaid, Senior Whole Health Plus of New York will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care and pharmacy items.

If there is a monthly premium for benefits (see Section 8 of the Senior Whole Health Plus of New York Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. To get more information about care management services, contact Member Services at 1-866-211-1777/TTY 1-866-404-9507. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

Additional Covered Services

Because you have Medicaid and qualify for the Medicaid Advantage Plus Program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, they are needed to prevent or treat your illness or disability. Your care manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in Senior Whole Health Plus of New York. If you cannot find a provider in our plan, contact Member Services for help at 1-866-211-

1777/TTY 1-866-404-9507. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

Benefit	Description of Covered Services	How to Receive Services
Adult Day Health Care	Adult Day Health Care means care and services provided to a registrant in a residential health care facility or approved extension site under the medical direction of a physician and which is provided by personnel of the adult day health care program in accordance with a comprehensive assessment of care needs and an individualized health care plan, and providing ongoing implementation and coordination of the health care plan, and transportation. Includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical and other ancillary services. Services furnished in approved SNF or extension site.	Contact Member Services for assistance.
Home Care Services (skilled)	Medicaid covered home health services include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and /or home health aide services as required by an approved plan of care developed by a certified home health agency. Includes nursing services and occupational and speech therapies.	Contact Member Services for assistance.
Home Delivered and Congregate Meals	Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.	Contact Member Services for assistance.
Inpatient Mental Health Care (days in excess of the Medicare 190-day lifetime maximum.)	Medically necessary care, including days in excess of the Medicare 190-day lifetime maximum.	Contact Member Services for assistance.
Medical Transportation (routine/non-emergent)	Transportation essential for an enrollee to obtain necessary medical care and services under the plan's benefits or Medicaid fee-for-service. Transportation services means transportation by	Contact Member Services for assistance.

Benefit	Description of Covered Services	How to Receive Services
	ambulance, ambulette, fixed wing or airplane transport, invalid coach, taxicab, livery, public transportation, or other means appropriate to the Enrollee's medical condition; and a transportation attendant to accompany the Enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Enrollee's family.	
Medical Social Services	Assessment, arranging and providing aid for social problems related to maintaining individual at home.	Contact Member Services for assistance.
Nutrition	Assessment of nutritional status/needs, development and evaluation of treatment plans, nutrition education and counseling, in-service education. Includes cultural considerations.	Contact Member Services for assistance.
Personal Emergency Response Services (PERS)	Personal Emergency Response Services (PERS) is an electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.	Contact Member Services for assistance.
Private Duty Nursing Services	Medically necessary private duty nursing services in accordance with ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.	Contact Member Services for assistance.
Social Day Care	Structured comprehensive program providing socialization; supervision, monitoring; personal care, nutrition in a protective setting during any part of the day; may include assistance with ADLs, case management, transportation.	Contact Member Services for assistance.
Social and Environmental Supports	Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	Contact Member Services for assistance.
Dental Services	Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.	Contact Member Services for assistance.

Benefit	Description of Covered Services	How to Receive Services
Skilled Nursing Facility (SNF)	Care provided in a SNF in excess of the Medicare 100 day limit per benefit period.	Contact Member Services for assistance.
Hearing Services	When medically necessary to alleviate disability caused by loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and prescriptions; and hearing aid products such as earmolds, special fittings and replacement parts.	Contact Member Services for assistance.
Vision Services	Coverage includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or the glasses are lost, damaged or destroyed.	Contact Member Services for assistance.
Personal Care Services	Personal care services (PCS) are the medically necessary provision of some or total assistance with such activities as personal hygiene, dressing and feeding; and nutritional and environmental support function tasks (meal preparation and housekeeping). Such services must be essential to the maintenance of the Enrollee's health and safety in own home.	Contact Member Services for assistance.
Outpatient Mental Health Treatment	Individual and group therapy visits. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.	Contact Member Services for assistance.
Outpatient Substance Abuse Treatment	Individual and group visits. Enrollee must be able to self-refer for one assessment from a network provider in a twelve (12) month period.	Contact Member Services for assistance.
Non-Medicare Covered Durable Medical Equipment	Non-Medicare covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, hearing aids and hearing aid batteries, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are	Contact Member Services for assistance.

Benefit	Description of Covered Services	How to Receive Services
	generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use.	

Service Authorizations and Actions

When Senior Whole Health Plus of New York determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from Senior Whole Health Plus of New York before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- Adult Day Health Care
- Dental Services
- Durable Medical Equipment
- Hearing Aids
- Home Delivered Meals (Meals on Wheels and Congregate Meal Programs)
- Home Health Care
- Inpatient Mental Health Care (over the 190 day Lifetime Medicare Limit)
- Inpatient Substance Abuse Care
- Medical Social Services
- Non-Emergency and Routine Transportation for health-related appointments
- Nursing Home Care Not Covered by Medicare
- Nutrition Services
- Outpatient Mental Health Care
- Outpatient Substance Abuse Care
- Oxygen and Respiratory Therapy
- Personal Care Services (assistance with bathing, eating and dressing)
- Personal Emergency Response Systems (PERS)
- Private Duty Nursing Services
- Prosthetics and Orthotics
- Rehabilitation Services including Occupational, Physical and Speech Therapies
- Social and Environmental Supports(chore services, home modifications or respite services)
- Social Day Care
- Vision Care

When you ask for approval of a treatment or service, it is called a **service authorization request**. To get a service authorization request, you or someone you appoint to act on your

behalf, must contact SWH at 1-866-211-1777/TTY 1-866-404-9507, Monday- Friday, 8a.m.- 8p.m., and also on Saturdays and Sundays from November 1st to March 15th, or your primary care physician. Your primary care physician's number is listed on the front of your Senior Whole Health Plus of New York identification card. You may also submit your request in writing to Senior Whole Health, 200 South Pearl Street, Albany NY 12202

Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This is called **concurrent review**.

What happens after we get your service authorization request?

The health plan has a review team to be 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 treatment plan against acceptable medical 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, who may be a doctor, a nurse or 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** 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 request will be handled under the standard review process. 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 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
- Fast track review: We will make a decision and you will hear from us within 3 work days. We will tell you by the third work day if we need more information.

Timeframes for concurrent review requests

- Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.
- Fast track review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 3 work days after we received your request.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. 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 as quickly as we can when we receive the necessary information, but no later than 14 days from the end of the original timeframe.

If you are not satisfied with our answer, you have the right to file an action appeal with us. See the Action Appeal section later in this handbook.

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 Senior Whole Health Plus of New York at 1-866-211-1777/TTY 1-866-404-9507, or by writing to Senior Whole Health, 200 South Pearl Street, Albany NY 12202. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

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.

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 reduce, suspend or terminate a service we have already approved and you are now getting within an authorization period, we must tell you at least 10 days before we change the service.

- 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.**

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Senior Whole Health Plus of New York does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-866-211-1777/TTY 1-866-404-9507, if you have a question about whether a benefit is covered by Senior Whole Health Plus of New York or Medicaid. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

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

Pharmacy

Most prescription drugs are covered by Senior Whole Health Plus of New York Medicare Part D as described in section 6 of the Senior Whole Health Plus of New York Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Senior Whole Health Plus of New York or Medicare. Medicaid may also cover drugs that we deny.

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:

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

Other Medicaid Services

- Methadone Treatment
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
- Adult Day Treatment for Persons with HIV/AIDS

- HIV COBRA Case Management

FAMILY PLANNING

Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

HIV TESTING AND COUNSELING

You can get HIV testing and counseling any time you have family planning services. You do not need a referral from your PCP (primary care provider). Just make an appointment with one of our family planning providers. Or, if you'd rather not see a Senior Whole Health Plus of New York provider, you can use your Medicaid card to see a family planning provider outside the Senior Whole Health Plus of New York provider network. For help in finding either a Plan provider or a Medicaid provider for family planning services, call Member Services at 1-866-211-1777. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

If you want HIV testing and counseling but not as part of a family planning service, your PCP can arrange it for you. Or you can visit an anonymous HIV testing and counseling site. For information, call the NYS HIV Counseling Hotline at 1-800-872-2777 or 1-800-541-AIDS. If you need HIV treatment after the testing and counseling service, your PCP will help you get follow-up care.

SERVICES NOT COVERED BY SWH MEDICAID ADVANTAGE PLUS PROGRAM

You must pay for services that are not covered by Senior Whole Health Plus of New York 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 Senior Whole Health Plus of New York or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Services of a Provider that is not part of the plan (unless Senior Whole Health Plus of New York sends you to that provider)

If you have any questions, call Member Services at 1-866-211-1777/TTY 1-866-404-9507. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st.

DISENROLLMENT FROM SENIOR WHOLE HEALTH PLUS OF NEW YORK MEDICAID ADVANTAGE PLUS PROGRAM

You Can Choose to Disenroll

You can ask to leave the Senior Whole Health Plus of New York Medicaid Advantage Plus Program at any time for any reason.

To request disenrollment, call Member Services at 1-866-211-1777 for help and to get the right forms. It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify.

You Will Have to Leave Senior Whole Health Plus of New York's Medicaid Advantage Plus Program if you:

- No longer are in Senior Whole Health Plus of New York for your Medicare coverage
- Need nursing home care, but are not eligible for institutional Medicaid because of a transfer of resources
- Are out of the plan's service area for more than 6 consecutive months
- Permanently move out of the Senior Whole Health Plus of New York service area
- No longer require a nursing home level of care
- Join a Long-Term Home Health Care Program, a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices of Mental Health, Mental Retardation and Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan

We will ask that you leave our Medicaid Advantage Plus Program if

- You are asked to leave our Medicare Advantage Plan,
- A family member behaves in a way that prevents our plan from providing the care you need, or you;
- You fail to pay money owed to our plan.

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether Senior Whole Health Plus of New York determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Sections 10 and 11 of Senior Whole Health Plus of New York's Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by Senior Whole Health Plus of New York you may choose to follow either the Medicare rules outlined in Sections 10 and 11 Senior Whole Health Plus of New York's Evidence of Coverage or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid

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complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of Senior Whole Health Plus of New York's notice of denial of coverage to use your Medicare complaint and appeal rights.

Senior Whole Health Plus of New York will explain the complaints and appeals processes available to you depending on the complaint you have. Call Member Services at 1-866-211-1777/TTY 1-866-404-9507 (toll free) to get more information on your rights and the options available to you.

MEDICAID RULES FOR APPEALS AND COMPLAINTS

Action Appeals

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

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan's Medical Director. The Medical Director will talk to your doctor within one workday.

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 45 business days after hearing from us to file an appeal.
- You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at 1-866-211-1777/TTY 1-866-404-9507 (toll free) if you need help filing an appeal.
- We will not treat you any differently or act badly toward you because you file an appeal.
- The appeal can be made by phone or in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

Your action appeal will be reviewed under the fast track process if:

- If you or your doctor asks to have your appeal reviewed under the fast track 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 appeal will be reviewed under the standard process; **or**
- 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.
- Fast track appeals can be made by phone and do not have to be followed up in writing.

What happens after we get your appeal?

- Within 15 days, we will send you a letter to let you know we are working on your appeal. We will let you know if we need additional information to make our decision.
- 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 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 by writing to Senior Whole Health, 200 South Pearl Street, Albany NY 12202.
- 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 appeals: If we have all the information we need, we will tell you our decision in 30 days from your appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.
- Fast track appeals: If we have all the information we need, fast track appeal decisions will be made in 2 working days from your appeal. We will tell you in 3 work days after giving us your appeal, if we need more information. We will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or fast track decision about your action appeal within the above timeframes we will:

- Write to tell you that we need more time to collect the information. 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;
- Take no more than 14 additional days to make a decision.

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 1-866-211-1777/TTY 1-866-404-9507 (toll free) or by writing to Senior Whole Health, 200 South Pearl Street, Albany NY 12202..

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 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 1-866-712-7197.

If your original denial was because we said the service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal, the

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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

In some cases you may be able to continue receiving the services while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

If we deny your appeal and you are not satisfied, you can appeal further using the External Appeals process or Fair Hearing process described below.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, you can ask New York State for an independent **external appeal**. This is called an external appeal because it is decided by reviewers who do not work for the health plan or the state. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

1. You must file an action appeal with the plan and get the plan's final adverse determination; **or**
2. If you had a fast track action appeal and are not satisfied with the plan's decision, you can choose to file a standard action appeal with the plan or go directly to an external appeal; **or**
3. You and the plan may agree to skip the plan's appeals process and go directly to external appeal.

You have 45 days after you receive the plan's final adverse determination to ask for an external appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the external appeal within 45 days of when you made that agreement.

Additional appeals to your health plan may be available to you if you want to use them. However, if you want an external appeal, you must still file the application with the State Department of Insurance within 45 days from the time the plan gives you the notice of final adverse determination or when you and the plan agreed to waive the plan's appeal process.

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 Insurance Department. You can call Member Services at 1-866-211-1777/TTY 1-866-404-9507 (toll free) if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-866-211-1777/TTY 1-866-404-9507 (toll free)

Your external appeal will be decided in 30 days. More time (up to five work days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

You can get a faster decision if your doctor says 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 three days or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may also ask for a Fair Hearing if the plan decided to deny, reduce or end coverage for a medical service. You may request a fair hearing and ask for 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.

Complaints

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services your receive from us, call Member Services at 1-866-211-1777/TTY 1-866-404-9507 (toll free) or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the Senior Whole Health Plus of New York Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the Senior Whole Health Plus of New York Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that Senior Whole Health Plus of New York determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment, or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint with the Plan:

To file by phone, call Member Services at 1-866-211-1777/TTY 1-866-404-9507. Our hours of operation are weekdays, Monday through Friday, from 8 a.m. to 8 p.m., and also on Saturdays and Sundays from November 15th to March 1st. If you call us after hours, leave a message. We will call you back the next working day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to Senior Whole Health, 200 South Pearl Street, Albany NY 12202.

What happens next?

If we don't solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don't have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have 60 business days after hearing from us to file an appeal;

SWH Member Services 1-866-211-1777 / TTY 1-866-404-9507

- You can do this yourself or ask someone you trust to file the appeal for you;
- The appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?

After we get your complaint appeal we will send you a letter within 15 working days. The letter will tell you:

- who is working on your complaint appeal
- how to contact this person
- if we need more information

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were not involved in making the first decision about your complaint.

We will let you know our decision within 30 working days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 working days of when we have all the information we need to decide the appeal. You will be given the reasons for our decision and our clinical rationale, if it applies. If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866-712-7197.

Fair Hearings

In some cases you may ask for a Fair Hearing from New York State.

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage Medicaid Advantage plus Program.
- You are not happy with a decision that Senior Whole Health Plus of New York made about one of the services that you were getting. You feel the decision limits your Medicaid benefits or that the plan did not make the decision in a reasonable amount of time.
- You are not happy with a decision that Senior Whole Health Plus of New York made that denied services. You feel that the decision limits your Medicaid benefits or that Senior Whole Health Plus of New York did not make the decision in a reasonable amount of time.
- You are not happy with a decision that your doctor would not order one of the services listed above that you wanted. You feel that the doctor's decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with Senior Whole Health Plus of New

SWH Member Services 1-866-211-1777 / TTY 1-866-404-9507

York. If Senior Whole Health Plus of New York agrees with your doctor, you may ask for a State Fair Hearing.

- In some cases, you may be able to keep getting care the same way while waiting for your Fair Hearing.

If you filed a complaint or appeal under Medicare rules, you may not then request a state Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

- By phone. Call toll free 1-800-342-3334
- By fax at 518-473-6735
- By Internet at www.otda.state.ny.us/oah/forms.asp
- By mail:

Fair Hearing Section
NYS Office of Temporary and Disability Assistance
P.O. Box 1930
Albany, New York 12201

Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at 1-866-211-1777/TTY 1-866-404-9507 (toll free) if you have any questions.