



MVHS
Senior Network
Health

Member Handbook



Our Phone Number: 315-624-4545

mvhealthsystem.org/SNH

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Welcome to the Senior Network Health (SNH) Long-Term Care Plan

We are pleased you have chosen us as your managed long-term care plan. We will strive to meet your needs to keep you a satisfied enrollee.

Your enrollment is effective the first day of the month following the processing of your enrollment paperwork with NYS Enrollment Broker.

An enrollment specialist will visit you in your home and complete a comprehensive assessment to develop a Plan of Care with you. If you choose to complete enrollment documentation with SNH, we will provide you with your handbook and provider directory at this time. Please take the time to review this upon receiving it and contact us with any questions.

A registered nurse has been assigned to you as a care manager who will ensure your individual needs are being met. He/she will also be available for any questions or concerns by calling the Enrollee Services department Monday through Friday from 8 a.m. to 4 p.m. at 315-624-4545, 315-866-8700 or 315-624-HOME (4663).

You can also call us 24/7 at our toll-free numbers: 888-355-4764, 315-624-4545, 315-866-8700 and 315-624-4663. A member of our Enrollee Services department will answer your call at any time to assist you, free of charge.

Please contact SNH if you have any questions or comments regarding your handbook or provider directory. If you'd like your handbook and directory sent to a new address, please be sure to contact us immediately.

Warmly,
The Senior Network Health Team

About SNH

Established in 1998, Senior Network Health (SNH) is an affiliate of the Mohawk Valley Health System (MVHS), a regional system of healthcare organizations and providers who are committed to bringing people and resources together to better plan and deliver accessible, high quality, cost-efficient health care services in the Mohawk Valley.

SNH has a network of area providers selected to assure you the best care possible. When you enroll, you are required to use the providers in our plan and to get authorization from your care manager for services covered by SNH.

What is Managed Long-Term Care and How Does It Work?

A managed long-term care plan is an organization that receives a capitated Medicaid rate to provide, arrange and coordinate health and long-term care services for the population the plan is authorized to serve.

We offer covered services through our network of providers and can coordinate other services including those covered by Medicare, Medicaid and private insurances. As an enrollee of SNH, you will benefit from:

- Coordination of all your healthcare services with your physician(s) and healthcare providers.
- A care manager, who is a registered nurse, who ensures that you are receiving the appropriate care you need.
- A plan of care that you, your care manager and your physician design specifically for you.
- Extensive choices in services, including preventive, rehabilitative and community-based services.
- Health professionals, including a care manager and administrator, who are on call 24 hours a day, seven days a week to answer your questions.

Enrollee Services

SNH wants you to understand your managed long-term care plan and receive the best possible care. The Enrollee Services Department was established to assist you with this. If you have any questions about benefits, services or procedures, or have a concern about any aspect of SNH, please let us know. Our Enrollee Services representatives are available to help you in any way regarding your enrolleeship. We welcome any ideas or suggestions you might have regarding SNH. Your comments help us improve our services.

Enrollee Services can be reached by telephone,
Monday through Friday, from 8 a.m. to 4 p.m.
315-624-4545 in Oneida County
315-866-8700 in Herkimer County
888-355-4764 toll-free

Interpreter Services

SNH is able to access interpreter services. If such a service is required, please request that the SNH care manager contact an interpreter in the language of your choice.

Services for Hearing-Impaired Enrollees

Hearing-impaired enrollees who wish to speak with an Enrollee Services representative and who have the capability to send messages through a TTY/TDD should first contact a Verizon relay operator at 1-800-662-1220, who will then facilitate calls between TTY/TDD users and voice customers. If you need a sign language interpreter, we can arrange that service for you, as well.

Services for Visually Impaired Enrollees

SNH has a large print handbook available upon request for those enrollees who are visually impaired. Please contact Enrollee Services to request a copy. Staff is also available to come to your house and read any material to you.

Note: You are not required to call SNH if you are having a medical emergency. **Call 911.**

Eligibility and Enrollment

Enrollment in SNH is voluntary. You may withdraw your application on the twentieth of the month prior to your enrollment date. If you are already a SNH enrollee, you may start the disenrollment process at any time.

Eligibility

Referrals for enrollment must be made to New York Medicaid Choice at 1-800-401-6582 or TTY: 1-800-329-1541, Monday through Friday, 8:30 a.m. to 8 p.m., Saturday, 10 a.m. to 6 p.m.

An applicant who is enrolled in any of the following plans/programs may be enrolled in the plan upon termination from that plan/program:

- Another managed care plan capitated by Medicaid.
- A home and community-based services waiver program.

If it is discovered upon screening that the applicant is enrolled in another managed care plan capitated by Medicaid, a Home and Community-based Services Medicaid Waiver program or State Office for People with Developmental Disabilities (OPWDD) Day Treatment Program or is receiving services from hospice, the applicant may be enrolled with SNH after terminating from other plans or services.

Applicants can receive assistance with disenrollment/transfer from their current plan/program by contacting: New York Medicaid Choice at 1-800-401-6582 or TTY: 1-800-329-1541, Monday through Friday, 8:30 a.m. to 8 p.m., Saturday, 10 a.m. to 6 p.m.

In order to be enrolled in SNH, you must meet all of the following requirements:

<ul style="list-style-type: none"> • You must be 18 years of age or older
<ul style="list-style-type: none"> • Be eligible for NYS Medicaid as determined by your Local Department of Social Services (LDSS)
<ul style="list-style-type: none"> • Live in Oneida or Herkimer County
<ul style="list-style-type: none"> • At the time of enrollment, have health problems and/or limitations that would qualify for nursing home level of care (medicaid only).
<ul style="list-style-type: none"> • Require at least one of the following community-based long-term care services and care management, from SNH for a continuous period of more than 120 days. <ol style="list-style-type: none"> 1. Nursing services in the home 2. Private-duty nursing 3. Therapies in the home 4. Home health aide services 5. Personal care services in the home 6. Adult Day Health Care 7. Consumer Directed Personal Assistance Services (CDPAS). • At the time of enrollment, be able to return home to/or remain safely at home without jeopardy to his/her health.

Learning about SNH

To find out more information about SNH, an enrollment coordinator can speak with you by phone or visit you in person. Within five business days of learning about your interest in SNH, a coordinator will make contact with you. He or she will review the above enrollment criteria chart to help determine if you are eligible to enroll in SNH, the enrollment process and what to expect from us. If it is decided that SNH is a good fit for you, a coordinator will schedule a home visit with a registered nurse who will administer the enrollment eligibility assessment.

Enrollment Process

If you are new to community base LTC services, you will need to have an assessment by a Conflict - Free Evaluator will complete a comprehensive assessment to determine your initial eligibility for Managed Long term Care Plan, SNH will establish your enrollment by also completing a comprehensive assessment to determine your Plan of Care for Community Based services. Applicants cannot be discriminated against based on their health status, and/or the need for or cost of services.

To start the SNH enrollment process, our registered nurse/enrollment coordinator will contact you via telephone within five business days of notification by the Conflict-Free Evaluation and Enrollment Center that you are eligible for enrollment.

The enrollment coordinator will arrange the first in-person visit within 30 days of the initial telephone contact. This visit will include a comprehensive health assessment. This process will enable the care manager to develop a tailored, individualized plan of care to meet your specific needs and preferences. At this time, a full explanation of SNH's managed long-term care plan will be discussed and you will have the opportunity to ask questions and to discuss your specific needs.

If you continue to be interested in enrolling with SNH, you will be required to sign an enrollment application forms, which includes a release of information so that SNH may have permission to contact the LDSS and your health care providers. We ask that you sign these important forms so that SNH can speak with your primary care physician and other healthcare providers to manage the services included in the plan of care. After the enrollment visit, SNH will make contact with your primary care physician to discuss a proposed care plan. If an enrollee is auto-assigned to SNH by NYS Medicaid Choice, this enrollee is presumed to be eligible for MLTC and SNH will initiate the enrollment process.

Enrollment will begin the first day of the month. Upon enrollment, you will be assigned a care manager and issued a SNH plan enrolleeship card. It is important that you bring this enrolleeship card, in addition to your Medicare and Medicaid cards and any other health insurance cards, to all healthcare appointments.

If you need additional home visits to help answer your questions about SNH, please contact us. Your enrollment in SNH is subject to review and approval by NYS Medicaid Choice.

Upon your enrollment, you will be issued a SNH enrollee ID card. This card, as well as your Medicaid and Medicare cards, is needed for all appointments.

Enrollment Eligibility Assessment

Well-experienced registered nurses act as enrollment specialists at SNH. They will help determine your clinical eligibility for SNH. They will do this by administering a health assessment which will help establish what level of care you need. They will also administer a health and safety assessment and a social and environmental assessment. In addition, a home assessment visit will be scheduled within five business days of your shown interest in SNH.

At your home visit, a plan of care will be developed with your and your family's input. At this time, you will be given an enrollment application by an enrollment specialist. However, you are not obligated to join. SNH is a voluntary program.

Enrollment is subject to approval by the NYS Enrollment Broker.

You may withdraw your application by noon on the 20th of the month. This can be done prior to the date of enrollment with a written statement or orally.

Denial of Enrollment

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

- Applicant is not 18 years of age.
- Applicant is not Medicaid-eligible.
- Applicant is not eligible for nursing home level of care (potential enrollee with Medicaid only).
- Applicant is not capable of returning to or remaining in the home without jeopardy to his/her health or safety at time of enrollment.
- Applicant does not require community-based, long-term care services from the SNH Managed Long-Term Care plan for 120 days of continuous services or more.
- Applicant has been previously involuntarily disenrolled from SNH.
- Applicant is currently enrolled in another Medicaid managed care plan, a home- and community-based services waiver program, a State Office for People with Developmental Disabilities (OPWDD) Day Treatment Program, or is receiving services from a hospice and does not wish to end his/her enrollment in one of these programs.
- Applicant is an inpatient or resident of a hospital or residential facility operated by the state Office of Mental Health (OMH), Office of Alcohol and Substance Abuse Services (OASAS) or the State OPWDD; applications for enrollment may be taken but enrollment may only begin upon discharge to the applicant's home in the community.

If it is determined that the enrollment should be denied by the criteria provided, SNH will recommend that the New York State Enrollment Broker denies enrollment. SNH will also notify the applicant. New York State Enrollment Broker will make the final decision in the denial of enrollment and will notify you of your rights.

You may withdraw your application by noon of the twentieth of the month prior to your enrollment month with a written or verbal statement.

If you are ineligible to join SNH based on your age, residence location or Medicaid eligibility, SNH will notify you. If you disagree with SNH's reasons for ineligibility, all information you have provided to SNH will be sent in writing to the New York State Enrollment Broker with a copy for yourself. The New York State Enrollment Broker will determine if SNH was correct in informing you that you're ineligible to enroll in SNH.

If it is determined that you are clinically ineligible to enroll in SNH, you will be notified and you may withdraw your application. Clinical ineligibility means that based on your in-home assessment, you do not require nursing home level of care (UAS-NY score of five or more for Medicaid only), and/or you do not meet health and safety criteria and/or you do not require community-based long-term care services of the plan for 120 continuous days.

If you do not wish to withdraw your application, it will be processed as a proposed denial pending the New York State Enrollment Broker agreement.

Care Team

All of your health needs will be coordinated and registered by a registered nurse care manager. He/she will also make periodic visits to your home to reassess your condition. SNH will arrange for the right care at the right time based on medical necessity. Your plan of care can be changed on an as-needed basis.

Your care team will include an assigned care manager, your primary care physician and other physicians providing you care as well as other SNH support staff. SNH support staff includes Enrollee Services coordinators, medical social workers, entitlement coordinators and our medical director. Together, SNH will work with you and your physicians to ensure you are receiving the best level of care. If your care manager notices changes in your health status, he/she will notify your primary care provider.

Care Manager

Your care manager is an employee of SNH and is the person you speak with when you call SNH about your long-term care needs. Your care manager will be responsible for coordinating solutions to meet your health and long-term care needs while ensuring quality outcomes with the goal to enhance your quality of life. Your care manager will put together a care plan keeping in mind your wishes, health and long-term care services. Each care manager is a registered nurse whose field of expertise is acute and long-term care services. He/she will discuss plans with you, the community care coordinator as well as your physicians to authorize and order the services outlined in your personal plan of care.

Your care manager will work cooperatively with your primary care physician as well as other healthcare professionals (such as your home healthcare provider, nurses and physical therapists) to coordinate all of your healthcare needs for both covered and non-covered services. Your care manager is matched, based upon availability, to best meet your individual language and cultural needs.

To contact your assigned care manager, call the Enrollee Services department at 315-624-4545 (Oneida Co.), 315-866-8700 (Herkimer Co.) or 1-888-355-4764.

Community Benefits/Social Work Department

The Community Benefits/Social Work department will work with you and your care manager to assist you with your social and environmental concerns. SNH is available to advise enrollees and their families on how to cope with chronic illness and social issues. With a referral from your care manager, a medical social worker will assist you with coordination of behavioral healthcare. Benefits coordinators can also assist you with applying for community benefits such as the Home Energy Assistance Program and food stamps, the Medicaid application and recertification process as well as any other benefits for which you are eligible. Contact your care manager for assistance.

Getting Help

SNH Enrollee Services department wants you to understand your managed long-term care plan and receive the best possible care. The Enrollee Services department exists for this purpose. If you need to reach your care manager; have any questions about benefits, services or procedures, or replacing a lost ID card; or have a concern about any aspect of SNH, please contact Enrollee Services. Our Enrollee Services coordinators are available by telephone to help you regarding your enrolleeship, including benefit questions, what services are or are not covered, to verify the date and time that you have scheduled appointments, or if you need to arrange medical transportation. These courteous staff enrollees work with your care team to schedule your appointments and order the supplies and services that you need. We also welcome any ideas or suggestions you might have regarding SNH.

Call Enrollee Services with your comments to help us improve our services to you at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll-free at 888-355-4764.

Hours of operation: Monday through Friday, 8 a.m. to 4 p.m.

24/7 NurseLine/After-hours Assistance:

If you have medical questions and cannot reach your PCP or care manager, or if it is after normal business hours (8 a.m. to 4 p.m.), you can always call SNH and speak directly to a nurse.

The 24/7 NurseLine can give you guidance about whether you should go to the emergency room, how to deal with a personal crisis in the home, or provide instructions on how to take your medications in accordance with your prescription.

We want you to know how to use your managed long-term care plan no matter what language you speak. The SNH staff speaks a limited variety of languages, but if you speak a language that our staff does not know, we can access an oral interpretation service (ATT Language Line) to make sure that you receive all of the information you need and that your questions are answered in your language. We also have written information in the most prevalent languages of our enrollees (English and Spanish). Oral interpretation of SNH written material is also available to all our enrollees in different languages. Taped English and Spanish versions of our enrollee handbook are also available upon request.

Please feel free to call Enrollee Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764 and request to speak to an interpreter or request written materials in your language.

Keep Us Informed

Call Enrollee Services whenever these changes happen in your life:

- You change your name, address or telephone number.
- You have a change in circumstances that may affect your eligibility for managed long-term care, such as changes in income/resources, your loss of medicaid or living conditions.
- You become covered under another health insurance such as a private health insurance.

Your ID Card

SNH enrollees will receive a SNH ID card. SNH phone numbers will appear on the front and back of this card. Carry your enrollee ID card at all times. You may use your ID card to receive services and benefits covered by the SNH Managed Long-Term Care Plan. You will also have continued coverage through Medicare and/or Medicaid fee-for-service and may have private insurance coverage for some of your medical needs. It is important that you carry all of your ID cards along with your SNH card.

You do not need to show your SNH ID card before you receive emergency care. Call 911 or go to the nearest emergency room. Below is a sample of what your SNH identification card will look like:



MVHS
**Senior Network
Health**

Senior Network Health, LLC
1650 Champlin Ave, Utica, NY 13502

Members: Please carry this card at all times. Show this card before you receive any covered MLTC services.

Providers: Medicare and/or other private insurance benefits are not affected by MLTC coverage. Please do not try to collect a copay or deductible from this individual. Please tell us of any inpatient activity. Please send MLTC claims to Senior Network Health.

Member Services: 315-624-4545
TTY: 711 or 800-662-1220
On-Call Care Manager: 315-624-4545



MVHS
**Senior Network
Health**

Senior Network Health, LLC
1650 Champlin Ave, Utica, NY 13502

Name:
Member ID:
Enrollment Date:
Group # Utica
EDI Payer ID: 20039
Customer Service/Preauthorization Required:
888-355-4764

Your Managed Long-Term Care Benefits

The following is a list of SNH covered and non-covered (coordinated) services available under the managed long-term care plan. All benefits and services are provided when medically necessary.

Medically Necessary

Services that are necessary to prevent, diagnose, correct or cure conditions with the enrollee that cause acute suffering, endanger life, result in illness or infirmity, interfere with such enrollee's capacity for normal activity or threaten some significant handicap.

Covered Services

Covered services are those services available through enrolleeship in managed long-term care, are generally rendered by a network provider and are paid for by SNH. The specific service and that service's frequency and duration are based upon your medical condition, health and social needs. All covered services can be arranged by SNH on your behalf. To schedule provider appointments or arrange non-emergency transportation, please contact your care manager or SNH Enrollee Services department who will do all of that for you.

Coordinated Services

Coordinated services are those services that are not covered by SNH. You may choose any provider for these non-covered services as long as that provider accepts Medicaid and/or Medicare, your third-party insurance coverage or you pay privately, as applicable by service.

Your SNH care manager will assist you by arranging and coordinating these services for you. It is extremely important that there is communication between all the providers involved in your care as well as collaboration with you and your family or informal supports.

Your care manager is an invaluable source of information and assistance, since the care manager's primary job is to serve as a liaison between you and all of your healthcare providers to assure the smooth and seamless provision of care regardless of payer source.

How to Obtain Covered Services.

For some covered services, you may need a physician's order and/or prior approval from SNH. For others, you may access the service directly.

Contact Enrollee Services or your care manager by calling 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764. Authorization is the process by which a covered service in SNH Managed Long-Term Care is determined to be medically necessary for the enrollee's condition, illness or ailment by the enrollee's physician and/or SNH.

The following is a list of covered services available through your participation in Senior Network Health:

- Audiology/hearing aids; hearing aid batteries - audiology services that include audiometric examination or testing, hearing aid evaluation, conformity evaluation and hearing aid prescription or recommendations if indicated.
- Care management - a process that assists enrollees to access necessary covered services as identified in the care plan.
- Dentistry - 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
- Durable medical equipment - includes medical/surgical supplies, prosthetics and orthotics, and orthopedic footwear, enteral and parenteral formula and hearing aid batteries.
- Enteral and parenteral supplements - enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding; or treatment of an inborn error of metabolism
- Home-delivered or congregate meals - meals provided to help support an enrollee's specific plan of care.
- + Home healthcare - 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.
- Medical/surgical supplies - 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
- Non-emergency transportation – transport by ambulance, taxi, van or livery service or public transportation to obtain necessary medical care and services.
- *+Nursing home care - continuous, skilled nursing care given in the home by properly licensed, registered professionals or licensed practical nurses.
- Nutritional counseling - offering the enrollee nutrition education and counseling to meet normal and therapeutic needs.

- Optometry/eyeglasses - includes the services of an eye doctor or optometrist, and includes exams and eye-glasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom made) and low-vision aids.
- Personal emergency response system - an electronic device used by certain high-risk patients so they can get help if they have a physical, emotional or environmental emergency.
- + Podiatry services - include routine foot care when illness, injury or symptoms involving the foot pose a danger, or when performed as necessary for medical care.
- Private-duty nursing - continuous, skilled nursing care given in the home by properly licensed, registered professionals or licensed practical nurses.
- Prosthetics – Prosthetics are a service or device that includes artificial arms, legs, internal body parts, breasts (including reconstructive breast surgery) and eyes.
- + Respiratory therapy - care to prevent breathing problems, to maintain breathing health or re-habilitate breathing using medicines, machines and patient education.
- Social day care - a structured, complete program that provides functionally impaired enrollees with socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of the day, and may include maintenance and enhancement of daily living skills, transportation, caregiver help and case coordination and assistance.
- Social and enviornmental supports- services and items that support the medical needs of the enrollee and are included in the enrollee's plan of care; they include home maintenance tasks, homemaker chore services, home modifications and respite care.
- + Rehabilitative Therapies: Physical, occupational, speech or other therapies in a setting other than the home rehabilitative services provided by a licensed, registered therapist; these services should help the enrollee restore as much of his or her physical or mental function as possible. Physical, occupational and speech therapy are limited to 20 visits per calendar year, except for children younger than age 21, or if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury.
- Adult Day Health Care is care and services provided in a residential healthcare 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.

- Medical social services means assessing the need for, arranging for and providing aid for social problems related to the maintenance of a patient in the home where such services are performed by a qualified social worker and provided within a plan of care. These services must be provided by a qualified social worker.
- Orthotics are appliances and devices used to support a weak or deformed part of the body or to restrict or eliminate motion in a diseased or injured part of the body.

*Institutional Medicaid eligibility rules apply

+Medicare coverage may apply

Your Care Manger will assist with coordination of non-covered outside of the SNH benefit package.

Coordination of Services

Plan of Care Development and Monitoring

When you enroll, your primary care physician, enrollment coordinator, and your assigned care manager will work together with you to help develop a plan of care that meets your needs. Your plan of care is a written description of all the types of services you will receive to help maintain and improve your health status and be as independent as possible. Your plan of care will include both SNH covered services and non-covered services. Your plan of care is developed based on initial and follow-up assessments (called reassessments) of your healthcare needs by a care manager.

Your initial plan of care is based upon the in-home assessment visit with the enrollment coordinator in collaboration with the recommendations of your physician and yourself to address your specific care needs. Reassessments will occur as rapidly as your condition requires but not longer than six months from the previous assessment. A copy of the SNH-approved plan of care will be provided to you no more than 15 calendar days from when your assessment or reassessment is completed or as rapidly as your condition requires.

Your plan of care is periodically evaluated and reviewed with you to help ensure the types of services you are receiving meet your specific needs. If your healthcare needs change, you may require different services or the same services, just more or less frequently. This will require that your plan of care changes. Your care manager will review the plan of care with you and your primary care physician and discuss any changes to your plan of care. The stability of your chronic condition will determine how often your plan of care is adjusted and how long it lasts. It may always be changed at any time as your medical needs increase or decrease, and we will notify you of any changes.

You are an important part of your healthcare team, so it is important for you to let us know what you need. Please talk with your primary care physician and care manager if you have a need for any service you are not currently receiving or wish to make changes in your plan of care (please see the section on “Requesting New or Additional Services” below). In addition, your care manager will work with you to help make certain that your medical conditions are being properly monitored.

Requesting New or Additional Services

How Do I Make Requests for Services?

Requests for new or additional benefits or services can be made orally or in writing to your care manager. Your provider, on your behalf, may also make a request for you. Any request that you make will be submitted to your assigned care manager for review.

For some requests, your care manager or your physician will conduct a medical necessity determination (please see the section on “Medical Necessity” on page 13) to help ensure that your request for a particular service or quantity of service(s) is most appropriate for your condition.

If an assessment is required, it will be conducted by the community care coordinator, or your physician, as fast as your condition requires or within three business days of receipt of your request. Once the medical necessity determination is completed, the care manager will discuss the evaluation with you, your family or informal supports.

Expedited Review

If SNH determines, or your provider indicates, that a delay in approving any service request would seriously jeopardize your life, health or ability to attain, maintain, or regain maximum function, the request will be expedited. You may also request an expedited review. If SNH denies the request for an expedited review, it will be handled using standard review time frames. SNH will send a written notice to you indicating that the request will not be handled as an expedited request, but will be handled as a standard request. You or your provider may file a complaint regarding the determination by SNH to complete the review using standard time frames. The care manager will notify you of any decision by phone and in writing as fast as your condition requires.

Prior Authorization (New Services)

When you, or a provider on your behalf, request a benefit or service you have never had before, it is considered a prior authorization request. A request to change a service in the plan of care for a future authorization period is also considered a prior authorization request. A prior authorization request decision will be rendered by phone and in writing as fast as your condition requires or within 72 hours of receipt of all necessary information, but not more than 14 days from the receipt of your request. For an expedited prior authorization request, you will be notified no more than 72 hours from the request for service.

Concurrent Review (More of the Same Services)

When you, or a provider on your behalf, request additional services (more of the same) that are currently authorized in the plan of care, the request is considered a concurrent review.

A concurrent review decision will be rendered by phone and in writing as fast as your condition requires or within one business day of receipt of all necessary information, but not more than 14 days from the receipt of your request by SNH. For expedited, concurrent review, you will be notified of the decision in one business day of receipt of necessary information, but not more than 72 hours of receipt of the request for services.

Extensions in Reviewing Requests

SNH may extend the review period by up to 14 days if we justify the need for additional information and the extension is in your best interest. You, or a provider on your behalf, can also request an extension verbally or in writing. SNH will send you a written notice of any extension that we initiate.

Prior Authorization and Concurrent Review Request Approvals

If your request is granted by SNH, the services will be authorized and ordered, and a confirmation letter will be mailed to you.

Prior Authorization and Concurrent Review Request Denials

If the determination by SNH is to deny coverage of your prior authorization request or concurrent review request, you will receive an Initial Adverse Determination Letter by mail that will explain the decision. You or your provider may appeal the decision rendered by SNH.

Appeal of an Adverse Determination

What is an Adverse Determination?

When SNH denies or limits coverage of 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 coverage of services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required time frames, those are considered actions. An action is subject to appeal.

Timing of an Adverse Determination

If we decide to deny or limit services you requested or decide not to pay for all or part of a 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 an Adverse Determination Notice

Any notice we send to you about an adverse determination will:

- Explain the determination we have taken or intend to take.
- Cite the reasons for the determination, 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 determination 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 explain how to ask for a Fair Hearing.
- 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 Internal Appeal of an Adverse Determination?

If you do not agree with an adverse determination that we have taken, you may appeal. When you file an adverse determination, 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 the initial adverse determination with the plan orally or in writing. When the plan sends you a letter about the initial adverse determination it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on our initial adverse determination letter notifying you.

How Do I Contact SNH to File an Appeal?

Call 1-315-624-4545 or 888-355-4764 (Toll Free number)
or write to: SNH Complaints and Appeals
1650 Champlin Avenue
Utica, NY 13502

For Some Adverse Determinants 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 to continue to receive these services within 10 days of the initial Adverse Determination. We must continue your service if you request no later than 10 days from the date of the initial adverse determination about the restriction, reduction, suspension or termination of services.

Although you may request a continuation of services, if the appeal determination has 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 SNH to Decide My Appeal?

Unless you ask for an expedited review, we will review your appeal action taken by us as a standard appeal and send you a written decision within two business day and 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 best 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 the coverage of requested services, or restricted, 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.

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. We will respond to you with our decision within 72 hours after we receive all necessary information. Enrollees will be told the decision by phone, with a written notice sent within 24 hours of the decision. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

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

If SNH 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 the state of New York and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to request to receive services while the hearing is pending and how to make the request.

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

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

State Fair Hearings

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within 120 calendar days of the date we sent you the notice about our final decision.

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 within 10 days from the date of the Final Adverse Determination, or the effective date of the decision, whichever is later, to keep your service the same.

Your benefits will continue until you withdraw the appeal or if 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 within 72 hours, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

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

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

- Online Request Form: <https://errswbnet.otda.ny.gov/errswbnet/erequestform.aspx>

- Mail a printable request form to:

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

- Fax a Printable Request Form: 518-473-6735
- Request by Telephone:
Standard Fair Hearing line – 1-800-342-3334
Emergency Fair Hearing line – 1-800-205-0110
TTY line – 711 (request that the operator call 1-877-502-6155)

- Request in Person:

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

Albany
40 North Pearl Street, 15th Floor
Albany, NY 12243

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

State External Appeals

If we deny your appeal because we determine coverage of the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from the state of New York. The external appeal is decided by reviewers who do not work for us or the state of New

York. These reviewers are qualified people approved by the state of New York. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Insurance within four months from the date we denied your appeal. Your external appeal will be decided within 30 days. More time (up to five 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 72 hours or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision. You may ask for both a fair hearing and an external appeal. If you ask for a fair hearing and an external appeal, the decision of the fair hearing officer will be the final decision.

Selection of Providers

Choosing Your Own Primary Care Physicians

Primary and acute care services are not covered services in the SNH Managed Long-Term Care plan. Instead, these services are covered by Medicaid and/or Medicare. This gives you the opportunity to maintain your relationship with your current primary care physician (PCP) to assure no disruption in medical care while gaining an additional support person, the care manager, to help guide your care. If, however, you want to change to a different PCP, your care manager will be happy to assist you in locating a qualified PCP.

Selection of Providers for Covered Services

For services covered by SNH, you may choose any provider from our network of providers that offers the service that you need. Since these network providers have a contractual obligation to SNH, we have the ability to monitor their services and hold them to our professional standards.

Effect on Enrollees with Medicare Coverage

If you have Medicare benefits, your enrolleeship in SNH MLTC does not affect your Medicare eligibility. You will continue to be covered by Medicare for your physician visits, hospitalizations, lab tests, ambulance and other Medicare benefits. You do not need authorization from SNH to receive Medicare services. If your Medicare benefits are exhausted and SNH becomes the primary payer for a covered service, you will need to switch to one of our network providers. However, for Medicare-covered services, SNH can:

- Refer you to a qualified physician (if you don't already have one).
- Schedule physician appointments and arrange non-emergency transportation for you.
- Arrange for nonemergency transportation to laboratory, X-ray or diagnostic tests that are ordered by your physician.

- Assist with discharge arrangements if you are admitted to a hospital.
- Arrange Medicare-covered home care services.

If you are receiving any services that are covered by both SNH and Medicare, Medicare will be billed as your primary insurance. If Medicare does not cover the entire cost of the service, then SNH will be billed for any deductibles or co-insurance.

If you are currently receiving a Medicare-covered service, you can continue using that provider. SNH recommends that you use a provider in our network so that you will not have to change providers if Medicare coverage limits are met and SNH becomes responsible for primary payment for the care.

If the provider of your choice is not in the SNH provider network, please contact your care manager or Enrollee Services to discuss your options.

Changing Provider(s)

SNH wants you to be happy with your provider for covered and non-covered services. If you are dissatisfied, we want to know about it, and we can help you change your provider.

To change your provider for covered services, contact our Enrollee Services department. The transition from one provider to another can happen in as little as one business day, but may take longer. We always attempt to match your provider with your location, primary language and specific healthcare needs.

SNH is also available to assist you in selecting or changing providers for non-covered services. Just contact our Enrollee Services department or care manager.

Emergency Care

You are NOT required to obtain pre-authorization or prior authorization from SNH to get emergency care.

Definition of an Emergency

An emergency is a sudden or unexpected illness, accident or injury that could cause severe pain, serious injury or death if it is not treated immediately. **If you have an emergency and need immediate medical attention, call 911 or go to the nearest hospital emergency room.** When possible, call your PCP or your care manager at SNH.

After An Emergency

Notify your PCP and your care manager at SNH within 24 hours of the emergency, if possible. You may be in need of long-term care services that can only be provided by SNH.

If You Are Hospitalized

If you are hospitalized, a family enrollee or informal support should contact SNH within 24 hours of admission. Your care manager will place your homecare services on hold and resched-

ule other appointments. If you are in the hospital, be sure to ask your primary care physician or hospital discharge planner to contact SNH. We will work with them to plan for your care upon discharge from the hospital.

Transitional, Out-of-Network and Out-of-Area Care

Transitional Care

Upon enrollment in SNH, you may continue an ongoing course of treatment for a transitional period of up to 90 days from enrollment with a non-network health care provider. Should your healthcare provider leave the SNH network, your ongoing course of treatment may be continued for a transitional period of up to 90 days .

The criteria listed below must be met in order for SNH to authorize and pay for transitional care:

- Your provider accepts SNH reimbursement rates as payment in full.
- Your provider makes available to SNH any medical information related to your care.
- Your provider agrees to follow SNH policies and procedures.

If you feel you have a condition that meets the criteria for transitional care services, please contact your care manager.

Out-of-Network Care

As a SNH enrollee, you may obtain a referral to a healthcare provider outside the network in the event SNH does not have a provider with appropriate training or experience to meet your needs. In the event you require an out-of-network provider, please contact your care manager to assist you in obtaining an authorization.

When using a provider outside of the SNH network for covered services, you must get an authorization from SNH before seeing the provider. Without first obtaining the required authorization, the provider will not be paid for services. If you have questions regarding this process, please call the Enrollee Services department at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764.

If You Are Leaving the SNH Service Area

The SNH service area is Oneida and Herkimer counties. If you are planning to spend some time away from home, please let your care manager know immediately. If you are planning to leave the service area for more than 30 consecutive days, it will be difficult for SNH to monitor your health needs properly. If this situation should occur, SNH will no longer be appropriate for you, and you must be disenrolled. In this case, you should call your care manager to discuss your options.

Out-of-Area Emergency Care

In the event of a medical emergency, call 911 or seek care in an emergency room even if you are out of your service area. After the medical emergency, your family or informal support should contact SNH within 24 hours, if possible, so we can possibly assist and also adjust your plan of

care to meet any changes in your medical needs.

Important Information about Advance Directives

You have a right to make your own healthcare decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can prepare ahead of time for situations in which you may be unable to make important healthcare decisions on your own. Preparing an advance directive will help ensure that all of your healthcare wishes are followed.

There are many different types of advance directives:

- **Health Care Proxy**

This document enables competent adults to protect their healthcare wishes by appointing someone they trust — a healthcare agent — to decide about treatment on their behalf when they are unable to decide for themselves.

- **Do Not Resuscitate Order**

You have the right to decide if you want emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want cardiopulmonary resuscitation you should make your wishes known in writing. Your primary care physician can 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. You can also complete the back of your New York state driver's license or non-driver identification card to let others know if and how you want to donate your organs.

- **Living Will**

You can give written specific instructions about treatment in advance of situations where you may be unable to make important healthcare decisions on your own.

- **MOLST (Medical Orders for Life Sustaining Treatments)**

It is your choice whether you wish to complete an advance directive and which type of advance directive is best for you. You may complete any, all or none of the advance directives listed above. The law forbids any discrimination against providing you medical care based on whether you have an advance directive or not.

The SNH enrollment packet contains forms to complete for advance directives. If you need additional forms, SNH will provide those to you if you wish to complete an advance directive. You

do not have to use a lawyer, but you may wish to speak with someone about this important issue. You can change your mind and these documents at any time. If you wish to make any changes, contact your care manager.

For more information regarding advance directives, please speak with your care manager or your primary care physician.

Addressing Your Problems and Concerns

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

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

To file a complaint or to appeal a plan action, please call:

315-624-4545 in Oneida County

315-866-8700 in Herkimer County

Toll free at 888-355-4764

Write to: Complaint/Grievance and Appeals SNH

1650 Champlain Avenue

Utica, NY 13502.

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

Complaints

What is a Complaint?

A complaint is any communication by you to SNH 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 SNH or one of our providers, you may file a complaint with us.

The Process

You may file a complaint orally or in writing with SNH. The person who receives your complaint will record it, and appropriate staff will oversee the review of the complaint. If your complaint can be immediately decided (same day) to your satisfaction, we will not respond in writing. We will send you a letter telling you we received your complaint and a description of our review process if we cannot resolve the issue to your satisfaction as quickly as the same day.

Our acknowledgment of the complaint will be sent within 15 business days of receipt. We will review your complaint and give you a written answer within one of two time frames:

- If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information and not more than seven calendar days.
- For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint.

Our answer will describe what we found when we reviewed your complaint/grievance and our decision about your complaint. All complaints, whether responded to in writing or not, will be logged, documented and tracked for quality improvement purposes.

How do I Appeal a Complaint Decision?

If you are not satisfied with the decision we make concerning your complaint, you may request a second review of your issue by filing a complaint appeal. You must file a complaint appeal in writing. It must be filed within 60 business days of receipt of our initial decision about your complaint. Once we receive your appeal, we will send you a written acknowledgement telling you the name, address and telephone number of the individual we have designated to respond to your appeal within 15 business days. All complaints will be conducted by appropriate professionals, including healthcare professionals for complaints involving clinical matters, who were not involved in the initial decision.

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

If you need assistance in filing your appeal due to language barriers, hearing, speech or other issues, our Enrollee Services department will assist you.

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.

If your appeal was filed orally, we will also provide you with a summary of the appeal as you described 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.

If You Wish to Disenroll (Voluntary Disenrollment)

You may initiate disenrollment at any time for any reason by oral or written notification to SNH. If you disenroll orally, we will provide you with written confirmation of receipt of your oral request.

Your care manager will discuss your decision over the telephone and, at your request, your care manager can meet with you in your home and attempt to resolve the circumstance that led up to your request to disenroll. If we are unable to resolve the issue, we will help you plan for your care following disenrollment. The effective date of disenrollment is the first day of the month. SNH will continue to provide and arrange for covered services until the effective date of disenrollment. SNH will notify you of the date that the disenrollment will take effect.

Any SNH Managed Long-Term Care plan enrollee who joins and/or receives services from another managed care plan capitated by Medicaid, a Home-and Community-based Medicaid Services Waiver program or an OPWDD Day Treatment Program is considered to have initiated disenrollment from SNH Managed Long-Term Care plan.

Transfers

If you require services such as personal care you must receive these services from a MLTC plan. These type of services are not available through your local department of social services. If you are not satisfied with SNH you may transfer to another MLTC plan to provide these types of services. Contact SNH enrollee services or your care manager to coordinate your plan to plan transfer.

- **Community-based Longterm Care Services may be obtained through a Managed Longterm Care Plan, Managed Care Plan or a Waiver Service Plan.**

Enrolleeship Cancellation (Involuntary Disenrollment)

If SNH feels that it is necessary to disenroll you involuntarily, we must obtain authorization from the New York State Enrollment Broker.

SNH will not involuntarily disenroll you on the basis of adverse change in health status or the need for and/or cost of covered services. The reasons for involuntary disenrollment are outlined below.

Involuntarily disenrolled enrollees will be notified of their appeal rights and fair hearing rights. SNH will continue to provide and arrange for covered services until the effective date of disenrollment .

You may be disenrolled from the SNH Managed Long-Term Care plan of care if:

- You, your family, informal support or informal caregiver engages in conduct or behavior that seriously impairs the ability of SNH to offer services to you or other enrollees.
- You fail to pay for, or make arrangements to pay, any amount owed as Medicaid spend down/surplus to SNH within 30 days after the amount becomes due, provided that during

that 30-day period SNH first makes a reasonable effort to collect the amount, including a written request for payment, and advising you in writing of your prospective disenrollment to down/surplus to Senior Network Health within 30 days after the amount becomes due.

- You knowingly fail to complete and submit any necessary consent or release.
- You knowingly file false information or otherwise deceive SNH or engage in fraudulent conduct with respect to any significant aspect of your plan enrolleeship.

You will be disenrolled from the SNH Managed Long-Term Care plan of care if:

- You are no longer eligible to receive Medicaid benefits.
- You no longer reside in the service area.
- You have been absent from the service area for more than 30 consecutive days.
- You are hospitalized or have entered an Office of Mental Health, State Office for People with Developmental Disabilities, Office of Alcohol and Substance Abuse Services residential program for 45 consecutive days or longer.
- You are no longer eligible for MLTC because you have been assessed using the New York State determined assessment tool as no longer demonstrating a functional or clinical need for community-based long term care services, or for non-dual eligible (only Medicaid) enrollees, in addition no longer meets the nursing home level of care.
- You become incarcerated. Your disenrollment date will be the first day of the month following incarceration.

Rights and Responsibilities as a Senior Network Health Enrollee

Your Rights include:

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.
- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand; you can get oral translation services free of charge.
- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your healthcare, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, nation origin, sexual orientation, marital status or religion.
- You have the right to be told where, when and how to get the services you need from

your managed long-term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.

- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and, the right to use the New York State Fair Hearing System and/or a New York State External Appeal, where appropriate.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to seek assistance from the Participant Ombudsman program.

Your Responsibilities include:

- To receive all of your covered benefits through SNH and get authorization for services as required.
- To provide clear and complete medical and personal information about yourself to your SNH providers and representatives.
- To contact us when you need help or have a question.
- To follow your plan of care that was agreed upon and request changes as needed.
- To make every effort to pay SNH any Medicaid surplus amount owed.
- To maintain Medicaid eligibility.
- To notify SNH when you go away or are out of town.

When you enroll, SNH receives a single monthly payment from Medicaid to provide and pay for all of the covered services listed on the Senior Network Benefit chart. No premiums, copayments or deductibles will be charged to you.

Payment of Providers by SNH

All SNH providers are under contract with us for the services they provide. SNH providers should never charge you a copay. If you receive a bill directly from a provider, call the Finance department at 315-624-8961, and it will resolve the situation for you.

If You Have a Medicaid Surplus

In the state of New York, you can receive Medicaid even if your monthly income is over the Medicaid allowable rate, as long as you are willing to pay what Medicaid calls a spend down or excess payment. This amount is determined by the Local Department of Social Services, and SNH is responsible for collecting that amount from you. If you owe a monthly surplus, you will receive a bill from SNH for the amount owed. If you fail to pay the amount owed within 30 days of receipt of the bill, SNH has the right to initiate disenrollment proceedings. If you have a Medicaid surplus, specific details regarding the payment process will be explained to you. Please see the section on Enrolleeship Cancellation (Involuntary Disenrollment) for more information. SNH Managed Long-Term Care plan will coordinate with other payers.

Medicare and other third-party insurances will be billed by providers before SNH Managed Long-Term Care plan will pay for the services. You are not liable for any payment related to covered services. If you are billed directly by a provider of covered services, you should contact the Finance department at 315-624-8961 so they can assist you in resolving this issue.

Information SNH Will Provide Upon Request

The following information shall be provided upon request of an enrollee or prospective enrollee:

- A list of the names, business addresses and official positions of the enrolleeship of the Board of Directors of SNH, including controlling persons, owners or partners of SNH.
- Information on the structure and operation of SNH
- A copy of the most recent annual certified financial statement of SNH, including a balance sheet and a summary of receipts and disbursements prepared by a certified public accountant.
- The procedures for protecting the confidentiality of medical records and other enrollee information.
- A written description of the organizational arrangements and ongoing procedure of the SNH Quality Assurance program.
- Individual health practitioner affiliations with participating hospitals, if any.

- Procedures followed by SNH in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatment.
- The written application procedures and minimum qualification requirements for healthcare providers to be considered by SNH.
- Specific written clinical review criteria relating to a particular condition or disease.

If you would like any of the above information, you or your designated representative can call 315-624-4545 or write to:

Senior Network Health
1650 Champlin Avenue
Utica, NY 13502

Simply indicate what documents you are requesting, and we will mail them to you within 10 business days.

Important Phone Numbers for SNH Managed Long-Term Care Plan

SNH Enrollee Services

315-624-4545-Oneida County
315-866-8700-Herkimer County
Toll free at 888-355-4764

SNH TTY

1-800-662-1220

Care Manager On Call Line

315-624-4545

Finance Department

315-624-8964

What to Do in a Medical Emergency

Call 911 or go to the nearest emergency room.

New York State Managed Long-Term Care Complaint Hotline

New York State Department of Health (Complaints)

Bureau of Managed Long Term Care

Room 1620

1 Commerce Plaza

Albany, NY 12210

1-866-712-7197

ICAN

ICAN helps people in New York's managed care plans who get long-term care services.

Their help is free, confidential, and independent.

Call (844) 614-8800 TTY Relay Service: 711

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

The original effective date of this notice was April 14, 2003. The most recent revision date was January 2018.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our enrollees. That means if you're an enrollee right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can approve and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- Used or shared by people who work for us, doctors or the state, we: Make rules for keeping information safe (called policies and procedures).
- On paper (called physical), we:
 - Lock our offices and files.
 - Destroy paper with health information so others can't get it.
 - Saved on a computer (called technical), we:
 - Use passwords so only the right people can get in.
 - Use special programs to watch our systems.

When is it OK for us to use and share your PHI?

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it's OK.

Sometimes, we can use and share it **without your OK** for your medical care, to help doctors, hospitals and others get you the care you need.

For payment, healthcare operations and treatment.

- To share information with the doctors, clinics and others who bill us for your care.
- When we say we'll pay for healthcare or services before you get them.
- To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment.

For healthcare business reasons.

- To help with audits, fraud and abuse prevention programs, planning, and everyday work.
- To find ways to make our programs better.

For public health reasons.

- To help public health officials keep people from getting sick or hurt.

With others who help with or pay for your care.

- With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK.
- With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you.

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws.

- To report abuse and neglect.
- To help the court when we're asked.
- To answer legal documents.
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death.
- To help when you've asked to give your body parts to science.
- For research.
- To keep you or others from getting sick or badly hurt.
- To help people who work for the government with certain jobs.
- To give information to worker's compensation if you get sick or hurt at work.

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. If you would like a copy of your whole medical record, ask your doctor or health clinic.
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email. If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

We may contact you

You agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system

and/or a pre-recorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Enrollee Services at 315-624-4545 in Oneida County, 315-866-8700 in Herkimer County or toll free at 888-355-4764. If you're deaf or hard of hearing, call 711.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Enrollee Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:

Office for Civil Rights U.S. Department of Health and Human Services Jacob Javits Federal Building:

26 Federal Plaza, Suite 3312

New York, NY 10278 .

Phone: 800-368-1019

TDD: 800-537-7697

Fax: 212-264-3039

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at www.mvhealthsystem.org/SNH

Your personal information

We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

We may use your PI to make decisions about your:

- Health
- Habits
- Hobbies

We may get PI about you from other people or groups like:

- Hospitals
- Other insurance companies
- Doctors
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.



Center for Rehabilitation
and Continuing Care Services
1650 Champlin Avenue
Utica, NY 13502

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