MANAGED LONG TERM HEALTH CARE PLAN

PRIME HEALTH CHOICE, LLC

GUIDE TO YOUR BENEFITS AND SERVICES
MEMBER HANDBOOK

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WELCOME TO PRIME HEALTH CHOICE, LLC MLTC PROGRAM

Dear Prime Health Choice Member,

Welcome to **PRIME HEALTH CHOICE, LLC** Managed Long-Term Care (MLTC) plan. The MLTC plan is especially designed for people who have Medicaid and who need health and Community Based Long Term Services and Supports (CBLTSS) 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 Prime Home Health Choice, LLC, covers since you're enrolled in the plan. It also tells you how to request service, file a complaint or disenroll from Prime Health Choice, LLC. Please keep this handbook as a reference, it includes important information regarding Prime Health Choice, LLC and the advantages of our plan. You need this handbook to learn what services are covered and how to get these services.

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

Prime Health Choice shall not unlawfully discriminate in access to enrollment or provision of services on the basis of age, sex, race, color, gender identity including status of being transgender, creed, religion, physical or mental disability including gender dysphoria, sexual orientation, source of payment, type of illness or condition, need for health services place of origin, or with regard to the Capitation Rate the Contractor will receive.

We look forward to working with you to improve your health and quality of life. At times, you may have questions about your care and various policies and procedures. We have prepared this book to answer common questions, and provide information about Prime Health Choice, LLC

Thank you for joining us, we look forward to serving you!

WELCOME TO PRIME HEALTH CHOICE, LLC MLTC PROGRAM

GUIDE TO YOUR BENEFITS AND SERVICES

PRIME HEALTH CHOICE, LLC

HELP FROM MEMBER SERVICES

Prime Health Choice, LLC wants you to understand your plan and receive services the best possible care available. The Member Services Department is there to help with this. You may call Member Services to speak to your Care Manager, ask questions about your covered benefits, get information about services and/or appointment times, replace a lost ID card, or arrange medical transportation. If you have questions about any aspect of your care coordinated by Prime Health choice, LLC, Member Services is there to help. You can call us at any time, 24 hours a day seven days a week, at the member services number below.

There is someone to help you at Member Services: Monday through Friday 9 AM-5PM.1 (855) 777-4630 or TTY/TDD: 1 (855) 777-4613 Monday- Friday. To ensure that enrollees have access to Care Management services 24 hours per day seven days a week for information, emergency consultation and response in the community, if necessary, other times you can call these numbers and the answering service will refer your call to the Case Manager On-Call who will return your call as soon as possible.

In an emergency, call 911 immediately, and notify us within 24 hours, if possible.

Interpreter Services
Please be advised that Prime Health Choice, LLC members are entitled to receive language interpretation services upon request at no charge to the member.
Our Care Team speak a variety of languages, but If you speak a language that our staff does not know, a member services representative can use the language line service, which has more than 100 languages and for visual impaired and hearing-impaired members, Prime Health Choice, LLC will provide appropriate devices as needed in order for member to be able to communicate via phone.

For Members who are Visually or Hearing Impaired
Members with hearing impaired or have vision/speech problems might utilize Text Telemetry Line ("TTY line") TTY/TDD: 1 (855) 777-4613 Monday- Friday or find the information on line at www.primehealthchoice.com

Please be advised that Prime HC members are entitled to receive language interpretation services upon request at no charge to the member.

PRIME HEALTH CHOICE, LLC

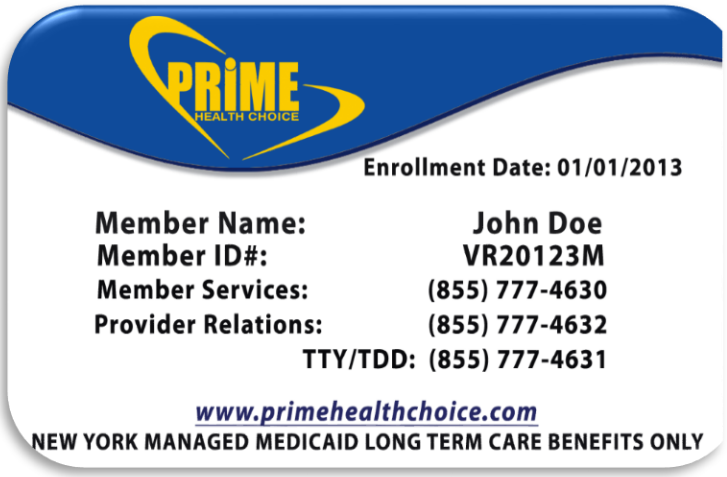
GUIDE TO YOUR BENEFITS AND SERVICES
HELP FROM MEMBER SERVICES

MEMBERSHIP CARD

You will receive your Prime Health Choice LLC Member Identification card (ID card), which will be provided within 10 days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Member Services at [855-777-4630]

Plan Member (ID) Card

You will receive your Prime Health Choice, LLC identification (ID) card within 10 days of your effective enrollment date. Please verify that all information is correct on your card. If your card becomes lost or stolen, please contact Member Service at (855-777-4630). Be sure to carry your ID car with you at all times along with your Medicaid card.



ELIGIBILITY FOR ENROLLMENT IN OUR PLAN

The MLTC plan is for people who have Medicaid. You are eligible to join the MLTC plan if you:

1) Are age 21 and older

2) Reside in the plan's service areas: Dutchess, Rockland, Albany, Orange, Putnam, Warren, or Washington County

3) Have Medicaid

4) Have Medicaid and are eligible for nursing home level of care

5) Capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, and

6) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the MLTC Plan for a continuous period of more than 120 days from the date of enrollment:

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
f. Private duty nursing; or
g. Consumer Directed Personal Assistance Services

The coverage explained in this Handbook becomes effective on the date of your enrollment in Prime Health Choice, LLC MLTC plan. Enrollment in the MLTC plan is voluntary.

NEW YORK INDEPENDENT ASSESSOR – INTIAL ASSESSMENT PROCESS

Effective May 16, 2022, the Conflict Free Evaluation and Enrollment Center (CFEEC) is now known as the New York Independent Assessor (NYIA). NYIA will manage the initial assessment process. NYIA will start the expedited initial assessments at a later date. The initial assessment process includes completing the:

- **Community Health Assessment (CHA):** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long-Term Care plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:

  o have a need for help with daily activities, ***and***

  o that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIA will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIA will complete a clinical appointment and PO a few days later.

Prime Health Choice, LLC will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/ or CDPAS for more than 12 hours per day on average, a separate review by the NYIA Independent Review Panel (IRP)will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, Plan of care, and any other medical documentations. If more information is needed, someone on the panel may examine you or discuss your needs with you. The IRP will make a recommendation to Prime Health Choice, LLC about whether the plan of care meets your needs.

Once NYIA completes the initial assessment steps and determines that you are eligible for Medicaid managed long term care, you then choose which managed long term care plan to enroll with.

ENROLLMENT PROCESS:

1. All applicants who are new to MLTC, looking to receive long term services for the first time must contact NYIA; who will conduct an evaluation to determine eligibility for CBLTC services. The NYIA will conduct an initial assessment for individuals who have expressed an interest enrolling in an MLTC plan.
2. Prime Health Choice, LLC will direct all calls from Medicaid recipients seeking a plan assessment for enrollment to the NYIA at 1-885-222-8350 (TTY: 1-888-329-1541)
3. Applicants who are transferring from another MLTC plan can join PHC in the first 90 days of enrollment or after a year of being enrolled to the previous plan. You do not need a NYIA evaluation if you're transferring from another MLTC plan. The initial assessment process by NYIA will be used to assess your individual's needs for personal care and / or consumer directed personal assistance services (PCS/CDPAS) eligibility for enrollment in a Managed Long -Term Care plan.
4. Applicants re – applying for enrollment after disenrolling voluntarily will follow the same procedure as any new applicant.
5. Once an individual has been qualified by NYIA, Prime Health Choice, LLC (PHC) Intake Department will make an appointment to schedule a home visit to develop the Person – Centered Service plan. PHC will conduct a visit with 30 days of the referral from the NYIA or at the request of the consumer for enrollment.

6. During the visit, the enrollment nurse from PHC will discuss an initial plan of care with you. The enrollment nurse will also review your Medicaid and Medicare information, if applicable, and will discuss and provide information about advanced directives, how to access covered and non – covered services, and your rights as a Prime Health Choice member.

Withdrawal of the Enrollment:

An applicant may withdraw his/ her application at any time during the enrollment process. The applicant may withdraw an application or enrollment agreement by noon on the 20th day of the month prior to the effective date of enrollment by indicating his/her wishes orally or in writing.

Applicants who have voluntarily signed an enrollment agreement and subsequently decided not to enroll in the program may submit a request to withdraw the application for enrollment. Prime Health Choice will notify the applicant in writing that they received the withdraw request.

Denial of Enrollment Process:
Your enrollment may be denied for any of the following reason:

- If you do not meet any of the above eligibility requirements.
- If you physician will not collaborate with us and you do not want to change your physician;
- If you do not reside within the counties of Prime Health Choice, LLC service area.
- If you're inpatient or resident of a hospital or residential facility operated under the auspices of the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse (OASAS) or the State Office of Person with Development Disabilities (OPWDD).
- If you are enrolled in another Managed Care plan capitated by Medicaid, a home or community – based service wavier program or a comprehensive Medicaid care management program (CMCM) or (OPWDD) Day Treatment program or you are receiving service from a Hospice program.
- You cannot be maintained safely at home or in the community.

The Development of the Initial Plan of Care

Your assigned nurse will work with you, your physician and your family to develop a Person- Centered plan (PCSP), that fits your particular needs. We make sure you receive the service you needed. Once the nurse assessment has been completed and you have reviewed your initial service plan and signed our plan enrollment application, we will begin processing your request for enrollment.

Your written Person- Centered plan (PCSP) covers the services you need, how often you need them, and for how long. It identifies, evaluates and helps you manage physical, emotional and social factors that affect your wellbeing. Your Person- Centered service plan is reviewed at least every six months, and more often, as your condition requires. As your needs change, your PCSP will change to meet those needs. Your nurse will review the plan of care and discuss any changes with you.

The PCSP content will include; all covered services, paid for you through PHC by Medicaid ; type , scope, amount frequency of services and authorization periods; problems identified during assessment; healthcare goals related to each problem; Your care manager will ensure that your primary care physician (PCP) is fully informed regarding any changes in your condition and your care manager will be contacting your physician at least 180 days or as often as your condition will warrant it. The PCSP will also include coordination of non – covered services by PHC, including physician, drug and other medical services that are paid directly by Medicaid or Medicare. You will receive a Person- Centered service plan after your initial assessment, or reassessment which are applicable within 15 days. The completed PCSP must be signed by you, a copy will be provided to you, and a signed copy will be retained by Prime Health Choice, LLC.

PARTICIPATING PROVIDERS AND COVERED SERVICES

You have the freedom to choose providers from Prime Health Choice's covered services provider network for us to cover the service. We will help you in choosing or changing a provider for covered or non- covered services.

Network providers will be paid in full directly by us for each service authorized and provided to you with no co- pay or cost to you. To find network providers in your neighborhood, check the current Provider Directory in your membership folder. If you receive a bill for covered services authorized by us, you are not responsible for paying the bill. Please contact your care manager. You may be responsible for payment of covered services that were not authorized by us or for covered services that were received from non-network providers.

Service Covered by The Prime Health Choice, LLC MLTC Plan:

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 also arrange appointments for any services you need and arrange for transportation to those services. Prime Health Choice, LLC managed long-term care (MLTC) Offers a wide range of home, community, and facility –based long -term care and health– related services.

Your care manager will work with you to provide or arrange services that are tailored to your needs. This means any health service that is needed to prevent, diagnose, correct, or cure (when possible) your health problems medical, social, educational, psychosocial, financial, and other services in support of the plan of care, irrespective of whether the needed services are covered by the Benefit Package.

Your Care Management team will monitor and reassess your health status and care needs. As your needs change, your plan of care will be changed. These changes may include increasing or decreasing services and changing the services provided to better meet your health are needs.

You will be assigned a care manager when you enroll. You can call your care management team at 1-855-777-4630, or TTY/TDD:1-855-777-4613 Monday-Friday 9am – 5pm. At other times, you can call this number and an answering service will refer your call to the case manager on – call and we will return your call as soon as possible. To ensure that enrollees have access to care management service 24 hours per day, seven days per week for information, emergency consultation services and response in the community, if **necessary.**

Your care manager will reach out to you by phone each month, and as necessary, to ensure that you're in good health and receiving all of the necessary services. Additionally, your care manager will conduct a telephonic reassessment every six months and work with you to develop a new plan of care. Once a year, a registered nurse will visit your home to evaluate you overall health and home environment, enabling them to develop a new plan of care.

Additional Covered Services

Because you have Medicaid and qualify for MLTC, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they're medically necessary, that is. They're 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 form from your doctor to get these services. You must get these services from the providers who are in Prime Health Choice, LLC Network.

If you cannot find a provider in our plan, you must let your care manager know, and he/she will decide with a non – network provider to provide the covered service for you. The service requested needs to be included in you benefits package and determined by the plan as covered by Medicaid and available from a network provider.

- **Outpatient Rehabilitation:** may be provided at an outpatient location based on your needs. These services include physical therapy, occupational therapy and speech language pathology and provided by licensed registered clinicians for the purpose of maximum reduction of physical and mental disability and restoration to your best functional level. Physical, Occupational and Speech Therapy are limited hospital in-patient setting, a skilled nursing facility or services provided by the Certified Home Health Agency.

- **Personal Care** such as assistance with bathing, eating, dressing, toileting, and walking. You can request these services through your Care Manager. Access to these services is based on an individual's care plan and must be authorized by your Care Manager before you receive the service.

- **Home Health Care Services Not Covered by Medicare** including care from nurses, physical therapists, occupational therapists, and speech therapists. These services are provided to help prevent, rehabilitate, guide and/or support your health and must be ordered by Physician and will be provided in your home.

- **Nutrition** including nutritional assessment, evaluation and development of treatment plans as well as nutritional counseling and education. You can request these services through your Care Manager. Access to these services is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Medical Social Services** including assessment, arranging for services and assistance to address social problems that impact your ability to live at home. Most medical social services will be provided by our social worker. If additional services are necessary, the services must be authorized by your care manager and included as part of your care plan.

- **Home Delivered Meals and/or Meals in a Group Setting** including meals provided at home, or in a group setting such as adult day care or senior centers. You can request these services through your care manager. Access to these services is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Social Day Care** which provides socialization, supervision, personal care, and nutrition in a protective setting. You can request these services through your care manager. Access to these services is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Non-Emergency Transportation**, New York City members can use public buses and trains to and from health care appointments without prior approval. Non-Emergency Medical Transportation shall mean transport by ambulance, ambulette, taxi or livery service or public transportation at the appropriate level for the enrollee's condition for the enrollee to obtain necessary medical care and services reimbursed under the New York State Plan for Medical Assistance or the Medicare Program. The plan is required to use only approved Medicaid ambulette vendors to provide ambulette transportation services to enrollees.

  In these cases, you must use network transportation providers. Access to these services is based on an individual's care plan and must be authorized by your care manager before you use the service.

  REMEMBER: If you need transportation for health-related services, be sure to call us at least two business days in advance if possible.

- **Private Duty Nursing** such as registered nurse services provided either in the home or facility. These services are based on an individual's care plan developed by your Care Manager. Before you receive this service, your physician must determine that it is medically necessary, and your care manager must authorize the service and include it in your care plan.

- **Dental Services** including necessary preventive, prophylactic, routine dental care and supplies as well as dental prosthetic and orthotic appliances required to improve a serious health condition. You will be assigned to a network dentist serving your area when your enrollment application is processed. However, you can change your dentist at any time by calling DentaQuest, or network dental provider, at 1-844-583-5038 from 8am to 8pm, Monday through Thursday, and Friday from 8am to 6pm. You may also call this number with questions about your dental benefits.

- **Social/Environmental Supports** (such as chore services, home modifications or respite care), You can request these services through your care manager. Access to these services is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Personal Emergency Response System** is a device that signals for help in the event of an emergency. You can request this service through your care manager. Access to this service is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Adult Day Health Care** includes medical, nursing, food and nutrition, social services, rehabilitation therapy, dental, pharmaceutical, leisure time activities and other ancillary services. Services are provided in an approved skilled nursing facility or extension site. You can request these services through your care manager. Access to these services is based on an individual's care plan and must be authorized by your care manager before you receive the service.

- **Nursing Home Care Not Covered by Medicare *(*provided you are eligible for institutional Medicaid*)*** Prime Health Choice, LLC will try to meet all health needs at home but there may be times when it is more appropriate for you to receive care in the nursing home setting. The decision to receive care in the nursing home must be made by you, your family, caregiver, your doctor, and your primary care manager.

  There are 2 types of nursing home stays:

  - Short-term or rehabilitation stays which are mainly after hospitalizations
  - Long-term stays for ongoing care.

- **Audiology-Hearing Aid Services** including testing and exams, hearing aid evaluations, hearing aid prescriptions and hearing aid products. These services are covered for MLTC members. When you need these services, your provider will get approval from us.

- **Durable Medical Equipment (DME)** includes medical/surgical supplies, medical equipment, respiratory therapy and oxygen and enteral and parental formulas. When you need these services, your primary care manager will consult with your doctor and arrange for delivery/installation

- **Medical Supplies** includes diapers, pull ups, chucks, pads, liners, and gloves. Access to these services are based on an individual's care plan and must be authorized by your primary care manager before you receive the service.

- **Prosthetics and Orthotics** Prime Health Choice, LLC will coordinate the provision of prosthetics appliances and devices that replace any missing parts of the body, orthotic appliances and devices support weak or deformed body parts, orthopedic footwear to prevent physical deformity or range of motion malfunction. Your primary care manager will consult with the doctor providing your care and will assist you if needed.

- **Optometry-Vision Service** including routine eye exams, eyeglasses and repairs and medically necessary contact lenses. These services are covered for all MLTC members. When you need these services, you may go to any network optometrists or ophthalmic dispenser for exams and eyeglasses without a referral or prior approval

- **Consumer Directed Personal Assistance Services (CDPAS)** provides personal care services, home health aide services or skilled nursing under the instruction, supervision and direction of the member or the member's representative. Access to these services is based on eligibility criteria and the member's care plan and must be authorized by your care manager before services are received.

Consumer Directed Personal Assistance Services means the provision of some or total assistance with personal care services, home health aide services and skilled nursing tasks by a consumer directed personal assistant under the instruction, supervision and direction of an enrollee or the enrollee's designated representative. Personal assistants are hired, trained and if necessary, fired by the enrollee or their designated representatives.

- Personal assistants are paid through a Fiscal Intermediary, which is an entity that has a subcontract with the contractor to provide wage and benefit processing and other fiscal intermediary responsibilities specified in subdivision in the event the enrollee is not self-directing, a designated representative will be identified to assume enrollee responsibilities for CDPAS. Such representative may not act as the enrollee's personal assistant.
- Prime Health Choice will ensure that all eligible enrollees are notified on initial assessment and at reassessment that CDPAS is an available voluntary benefit.

- **Podiatry Services** includes routine foot care provided by a podiatrist when your physical condition poses a hazard due to the presence of localized illness, injury or symptoms involving the foot, resulting from the diagnosis and treatment of diabetes, ulcers, and infections. Routine hygienic foot care, including treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

- **Respiratory Therapy** includes preventive, maintenance and rehabilitative services provided by qualified respiratory therapy professional.

- **Health Education** is available for all our members on the Prime Health Choice, LLC'S website. Your Care Manager is always available to answer any question you have about your health condition. Please do not hesitate to call him/her. The phone number is listed at the front of this handbook.

Limitations

Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1. tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; ***and***
2. individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Nursing Home Care is covered for individuals who are considered a permanent placement for at least three months. Following that time period, your Nursing Home Care may be covered through regular Medicaid, and you will be disenrolled from Prime Health Choice, LLC.

Getting Care outside the Service Area

You must inform your Care Manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your Care Manager should be contacted to assist you in arranging services.

EMERGENCY CARE

If you have an emergency medical condition, you do not need to contact Prime Health Choice, LLC before getting care. You do not need to worry about whether the emergency service is authorized or if the provider is part of the Prime Health Choice, LLC Provider Network.

An emergency medical condition is a health problem that happens suddenly or very rapidly. To be considered an emergency, the problem will include pain or other symptoms that are so severe that an average person - that is, someone like a Prime Health Choice, LLC member without special knowledge of health or medicine - would believe that there would be serious consequences if he/she did not get immediate help. These consequences could include serious jeopardy to your health, damage to your bodily functions or organs, or serious disfigurement.

The official New York State definition of an emergency medical condition is a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual, or in the case of a Behavioral condition, placing the health of the person or others in Serious jeopardy.
- serious impairment to bodily functions.
- serious dysfunction of any bodily organ or part of such person.
- serious disfigurement of such person.

Emergency Service

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

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

TRANSITIONAL CARE PROCEDURES

New members in Prime Health Choice, LLC may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to Prime Health Choice quality assurance and other policies, and provides medical information about the care to your plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

MONEY FOLLOWS THE PERSON (MFP)/OPEN DOORS

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

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

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

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

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

Prime Health Choice will make every effort to have a contract with at least one veteran's home that operates within our service area. Upon enrollment into Prime Health Choice, the Plan will notify each member requiring long term placement about the availability of a veteran's home in our Prime Health Choice Provider Network.

A list of the providers who are in the Prime Health Choice Provider Network was given to you upon enrollment and you will automatically receive an updated directory each year. If we are unable to provide you with admission to a veteran's home in our service area, we will arrange for you to temporarily go "out of the network" until you can be transferred to another MLTC Plan that contracts with an in-network veteran's home.

If Prime Health Choice MLTC Plan does not operate in an area with an accessible veteran's home, or does not have one in our network, we will direct you to the enrollment center. We will inform the enrollment center of the matter and provide the enrollment center with your information for an easy transfer to another MLTC Plan.

VETERAN'S PROTECTIONS

Prime Health Choice will make every effort to have a contract with at least one veteran's home that operates within our service area. Upon enrollment into Prime Health Choice, the Plan will notify each member requiring long term placement about the availability of a veteran's home in our Prime Health Choice Provider Network.

A list of the providers who are in the Prime Health Choice Provider Network was given to you upon enrollment and you will automatically receive an updated directory each year. If we are unable to provide you with admission to a veteran's home in our service area, we will arrange for you to temporarily go "out of the network" until you can be transferred to another MLTC Plan that contract with an in-network veteran's home.

If Prime Health Choice MLTC Plan does not operate in an area with an accessible veteran's home, or does not have one in our network, we will direct you to the enrollment center. We will inform the enrollment center of the matter and provide the enrollment center with your information for an easy transfer to another MLTC Plan.

Please read this Handbook carefully for more information on these topics. Your Care Manager or Member Services Representative is also available to answer any questions you have about Prime Health Choice. Please do not hesitate to call them; their phone numbers are listed at the front of this Handbook.

Medicaid Services Not Covered By Our Plan

There are some Medicaid services that Prime Health Choice, LLC does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid benefits card. Call member service at 1-855-777-4630 if you have a question about whether a benefit is covered by Prime Health Choice or Medicaid. Some of the services covered by Medicaid using your Medicaid benefit card include:

Pharmacy

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

Certain Mental Health Services, including:

- Intensive Psychiatric Rehabilitation Treatment
- Day Treatment
- Case management for seriously and persistently mentally iii (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Service to those in community homes or in family- based treatment
- Continuing Day Treatment
- Assertive Community Treatment

Personalized Recovery Oriented Services

Certain Intellectual and Developmental Disabilities Services, including:

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

Other Medicaid Services including:

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

Certain medically necessary ovulation enhancing drugs, when criteria are met.

SERVICES NOT COVERED BY PRIME HEALTH CHOICE, LLC OR MEDICAID

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

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a Provider that is not part of the plan (unless Prime Health Choice, LLC sends you to that provider)

If you have any questions, call Member Services at 1(855) 777-4630

SERVICE AUTHORIZATIONS, ACTIONS AND ACTION APPEALS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To submit a service authorization request, you must speal with your Care Manager if you have any questions about your services and our authorization procedures. Prime Health Choice, LLC provides all services based on medical necessity. If you believe you need any of the services that require approva advance, you must call your Care Manager or send a request in writing to obtain authorization.

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period.**

Prior Authorization (New Services)

Certain services that are covered require pre – approval from the care management team of PHC plan before you can receive them, or continue receiving them. You or a trusted individual can request this authorization. A team of medical professionals, including doctors and nurses, will review your request for service authorization. Their responsibility is to ensure that the treatment or service you are seeking is necessary and appropriate for your conditions. This process involves comparing your treatment plan against established medical guidelines. The following treatments and services must be approved before you get them:

- Dental Care – You do not need an authorization to see your dentist for a check-up twice a year and basic dental services. However, if you need a more complex dental service, it will require authorization in advance. Your dentist will obtain these authorizations for you.
- Optometry and eyeglasses – You do not need an authorization to have an eye exam from an optometrist once a year or to get new glasses yearly. However, an authorization is required if you need these services more frequently.
- Podiatry – For most members, podiatry care is covered by Medicare. However, an authorization is required if the services you need are not covered by Medicare.

WHAT HAPPENS AFTER SERVICE AUTHORIZATION REQUEST?

Concurrent Review (More of the same Service)
You can also ask the care management team that gives prior authorization on behalf of PHC to get more of a service than you're getting now. This is called **concurrent review.**

Retrospective Review (More of the same Service)
Sometimes we will do a review on the care you're getting to see if you still need the care. We may also review other treatments and services you already got**.** This is called **retrospective review.** We will tell you, if we do these reviews.

What happens after we get your service authorization request?
The 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.

We may decide to deny a service authorization request or to approve it for an amount that is less than requested. 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 clinical peer reviewer, who may be a doctor, a nurse or health care professional who typically provides the care requested. You can request the specific medical standards, called **clinical review criteria,** used to make decisions 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 indicated below.

Time frames 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 received 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 72 hours. We will tell you within 72 hours if we need more information.

Time frames for concurrent review requests:

- **Standard review:** We will make a decision within 1 workday 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 workday of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 workday if we need more information.

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 last day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1(855) 777-4630 or writing to **PRIME HEALTH CHOICE, LLC: 3125 EMMONS AVENUE, BROOKLYN, NY 11235 (FAX#):1-718-513-7370**

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.

If our answer is YES to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

If our answer is NO to part or all of what you asked for, we will send you a written notice that explains why we said no. See **How do I File an Appeal of an Action?** which explains how to make an appeal if you do not agree with our decision.

What is an Action?

When **Prime Health Choice, LLC** denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; restricts, reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make complaint or appeal determinations within the required timeframes, those are considered plan "actions. An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action

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

Contents of the Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe the availability of the clinical review criteria relied upon in making the decision, if the involved issue of medical necessity or whether the treatment or service in question was experimental or investigational; **and**.
- 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 rights to appeal and a State Fair Hearing:

- It will explain the difference between an appeal and a fair hearing.
- It will say that you must file an appeal before asking for a fair hearing; **and**
- It will explain how to ask for an appeal.

If we are reducing, suspending, or terminating an authorized service the notice will also tell you about your rights to have your services continued while your appeal is decided. To have your services continued you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I File an Appeal of an Action?
If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 60 days of the date on the notice. If we are reducing, suspending or terminating and authorized service and you want your services to continue while your appeal is decided, you must ask for an appeal within 10 days of the date on the notice or the intended effective date of the proposed action, whichever is later.

How do I contact my plan to file an Appeal?
We can be reached by calling 1(855) 777-4630 or writing to **PRIME HEALTH CHOICE, LLC: 3125 EMMONS AVENUE, BROOKLYN, NY 11235** The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a notice telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process
If you are appealing a restriction, reduction, suspension or termination of services you are currently authorized to receive, you must request a plan appeal to continue to receive these services while your appeal is decided. We must continue your service if you ask for a plan appeal no later than 10 days from the date on the notice about the restriction, reduction, suspension or termination of services or the intended effective date of the proposed action, whichever is later. To find out how to ask for a plan appeal, and to ask for aid to continue, see "**How do I File an Appeal of an Action?"** above.

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

How Long Will It Take the Plan to Decide My Appeal of an Action?
Unless your appeal is fast tracked, we will review your appeal of the action taken by us as a standard appeal. We will send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.) During our review you will have a chance to present your case

in person and in writing. We will also send you your records that are part of the appeal review.

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

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

Fast Track Appeal Process

We will always expedite our review if the appeal is about your request for more of a service you are already receiving. If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for a fast-tracked review of your appeal. of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 72 hours after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information, and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for a fast-track 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 a fast-track appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Note: **You must request a Fair Hearing within 120 calendar days after the date on the Final Adverse Determination Notice.** If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we deny your plan appeal or fail to provide a Final Adverse Determination notice within the timeframes under **"How Long Will It Take the Plan to Decide My Appeal of an Action?"** *above*, you may request a Fair Hearing from New York State. The Fair Hearing decision can overrule our decision. You must request a Fair Hearing within 120 calendar days of the date we sent you the Final Adverse Determination notice. If we are reducing, suspending or terminating an authorized service and you want to make sure that your services continue pending the Fair Hearing, you must make your Fair Hearing request within 10 days of the date on the Final Adverse Determination notice.

Your benefits will continue until you withdraw the Fair Hearing or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. 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 (OTDA):

- Online Request Form: Request Hearing | Fair Hearings | OTDA (ny.gov)
- Mail a Printable Request Form:
  NYS Office of Temporary and Disability Assistance
  Office of Administrative Hearings
  Managed Care Hearing Unit P.O. Box 22023 Albany, New York 12201-2023
- Fax a Printable Request Form: (518)473-6735
- Request by telephone:
  Standard Fair Hearing line – 1(800)342-3334
  Emergency Fair Hearing line – 1(800)205-0110
  TTY line – 711(request that the operator call 1(877) 502-6155)
- Request in Person:
  New York City
  14 Boerum Place, 1st floor
  Brooklyn, New York 11201

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

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

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

State External Appeals

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

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

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

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called a fast-track external appeal. The external appeal reviewer will decide a fast-track 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 "one that counts."

COMPLAINTS AND COMPLAINT APPEALS

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

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

To file a complaint, please call: Member Service at 1(855)-77-4630 or write to: **Prime Health Choice, LLC: 3125 Emmons Ave, Brooklyn, NY 11235.** When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Complaint?

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

The Complaint Process

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

1. If a delay would significantly increase the risk to your health, we will decide within 48 hours after receipt of necessary information, but the process must be completed within 7 days of the receipt of the complaint.
2. For all other types of complaints, we will notify you of our decision within 45 days of receipt of necessary information, but the process must be completed within 60 days of the receipt of the complaint. The review period can be increased up to 14 days if you request it or we need more information and the delay is in you interest.

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

How do I appeal a complaint decision?

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

For standard complaint 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 fast-track complaint appeal process. For fast-track complaint, we will make our appeal decision within 2 business days of receipt of necessary information. For both standard and fast track complaint appeal, we will provide you with a written notice of our decision of your complaint appeal. The notice will include the detailed reason for our decision and, in cases involving clinical matters, the clinical rational for our decision.

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can get free independent advice about your coverage, complaints, and appeal options. They can help you manage the appeal process. They can also provide support before you enroll in a MLTC plan like Prime Health Choice, LLC. This support includes unbiased health plan choice counseling and General plan related information. Contact ICAN to learn more about their services:

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

Long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC plan, Medicaid managed care plan or home and community based wavier program, in order to receive CBLTSS.

Voluntary Disenrollment
You can ask to leave the Prime Health Choice, LLC at any time for any reason.

To request disenrollment, call 1(855)777-4630 or you can write to us. The plan will provide you with written confirmation of your request. We will include a voluntary disenrollment form for you to sign and send back to us. 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

Transfers
You can try our plan for 90 days. You may leave Prime Health Choice, LLC and transfer and join another plan at any time during that time. If you do not leave in the first 90 days, you must stay in Prime Health Choice, LLC for nine more months, unless you have good reason (good cause).

- You move out of our service area.
- You, the plan, and your county Department of Social Services or the New York State Department of Health all agree that leaving Prime Health Choice LLC is best for you.
- Your current home care provider does not work with our plan.
- We have not been able to provide services to you as we are required to under our contract with the state.

If you qualify, you can change to another type of managed long-term care plan like Medicaid Advantage Plus (MAP) or Programs of All-Inclusive Care for the Elderly (PACE) at any time without good cause.

To change plans: Call New York Medicaid Choice at 1-888-401-6582. The New York Medicaid Choice counselors can help you change health plans.

It could take between two and six weeks for your enrollment into a new plan to become active. You will get a notice from New York Medicaid Choice telling you the date you will be enrolled in your new plan. Prime Health Choice, LLC will provide the care you need until then.

Call New York Medicaid Choice if you need to ask for faster action because the time it takes to transfer plans will be harmful to your health. You can also ask them for faster action if you have told New York Medicaid Choice that you did not agree to enroll in Prime Health Choice, LLC.

Involuntary Disenrollment

An involuntary disenrollment is a disenrollment initiated by Prime Health Choice, LLC. If you do not request voluntary disenrollment, we must initiate involuntary disenrollment within five (5) business days from the date we know you meet any of involuntary disenrollment reasons.

You will have to leave Prime Health Choice, LLC if you are:

- No longer are Medicaid eligible
- Permanently move out of Prime Health Choice service area.
- Out of the plan's service area for more than 30 consecutive days.
- Needing nursing home care but are not eligible for institutional Medicaid.
- Hospitalized or enter an office of Mental Health, office for People with Development Disability or office of Alcoholism and Substance Abuse services residential program for forty-five (45) consecutive days or longer.
- Assessed as no longer having a functional or clinical need for (CBLTSS) on a monthly basis.
- Medicaid only and no longer meet the nursing home level of care as determined using the designated assessment tool.
- Receiving Social Day Care as your only service.
- No longer require, and receive, at least one CBLTSS in each calendar month.
- At the point of any reassessment, while living in the community, you are determined to no longer demonstrate a functional or clinical need for CBLTSS.
- Incarcerated
- Providing the plan with false information, otherwise deceive or engage in fraudulent conduct with respect to any substantive aspect of your plan membership.

We can ask you to leave Prime Health Choice **if you:**

- Or family member or informational caregiver or other person in the household engages in conduct or behavior that seriously impairs the plans' ability to furnish services.
- Fail to pay or make arrangements to pay the amount money, as determined by the Local Department of Social Services, owed to the plan as spenddown/surplus within the 30 days after the amount first becomes due. We will have made a reasonable effort to collect.

Before being involuntary disenrolled Prime Health Choice, LLC will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which you become ineligible for enrollment. If you continue to need CBLTSS you will be required to choose another plan or you will be automatically assigned (auto- signed) to another plan.

CULTURAL AND LINGUISTIC COMPETENCY

Prime Health Choice, LLC honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all members. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

CULTURAL AND LINGUISTIC COMPETENCY

1. Prime Health Choice shall promote and ensure the delivery of services in a culturally competent manner to all Enrollees, including, but not limited to, those with limited English proficiency and diverse cultural and ethnic backgrounds as well as Enrollees with diverse faith communities. For the purposes of this Agreement, cultural competence means having the capacity to function effectively within the context of the cultural beliefs, behaviors, and needs presented by Enrollees and their communities across all levels of the Prime Health Choice's organization.
2. In order to comply with this section, Prime Health Choice shall:
    - **a.** Maintain an inclusive, culturally competent provider network;
    - **b.** Adopt policies and procedures that incorporate the importance of honoring Enrollees' beliefs, sensitivity to cultural diversity, fostering respect for Enrollees' culture and cultural identity, and eliminating cultural disparities;
    - **c.** Maintain a Cultural Competence component of the Prime Health Choice's Internal Quality Assurance program referenced in Article V.(F) of this Agreement;
    - **d.** Develop and execute a comprehensive cultural competence plan based on Culturally Linguistically Appropriate Services (CLAS) national standards of the US Department of Health and Human Services. Office of Minority Health and managed through the Contractor's Internal Quality Assurance Program;

e. Perform internal cultural competence activities including, but not limited to conducting:

- Organization-wide cultural competence self-assessment;
- Community needs assessments to identify threshold populations in each Service Area in which the Contractor operates; and Care
- Quality improvement projects to improve cultural competence and reduce disparities, informed by such assessments and CLAS standards.

f. Facilitate annual training in cultural competence for all the Prime Health Choice's staff members. All elements of the curriculum shall be consistent with and/or reflect CLAS national standards. The Prime Health Choice's cultural competence training materials are subject to the review and approval by the State. The Plan shall ensure the cultural competence of its provider network by requiring Participating Providers to certify, on an annual basis, completion of State-approved cultural competence training curriculum, including training on the use of interpreters, for all Participating Providers' staff who have regular and substantial contact with Enrollees. The State will provide cultural competence training materials to the Plan and providers upon request.

MEMBER RIGHTS AND RESPONSIBILITIES

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

Member Rights

- 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 records 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 health care, including the right to refuse treatment.
- You have the right to be free from any form of restrain or seclusion used as a means of coercion, discipline, convivence or retaliation.
- You have the right to get care without regard to sex, race, health status, color, age, national region, sex 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.
- You have the right to use the New York State Fair Hearing System and /or 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.

Member Responsibilities

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

IMPORTANT INFORMATION ABOUT YOUR PRIVACY RIGHTS

Notice of Privacy Practices
Effective February 1, 2012

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

We respect the confidentiality of your health information. We are required by federal and state laws to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you about your rights with respect to your health information and how you can exercise these rights.

We use security safeguards and techniques designed to protect your health information that we collect, use, or disclose orally, in writing and electronically. We train our employees about our privacy policies and practices, and we limit access to your information to only those employees who need it in order to perform their business responsibilities. We do not sell information about our customers or former customers.

HOW PRIME HEALTH CHOICE WILL USE OR SHARE INFORMATION

We may use or share information about you for purposes of payment, treatment, and health care operations, including with our business associates. For example:

- **Payment:** We may use your information to process and pay claims submitted to us by you or your doctors, hospitals, and other health care providers in connection with medical services provided to you.
- **Treatment:** We may share your information with your doctors, hospitals, or other providers to help them provide medical care to you. For example, if you are in the hospital, we may give the hospital access to any medical records sent to us by your doctor.

- **Health Care Operations:** We may use and share your information in connection with our health care operations. These include, but are not limited to:
- Sending you a reminder about appointments with your doctor or recommended health screenings.
- Giving you information about alternative medical treatments and programs or about health-related products and services that you may be interested in. For example, we might send you information about stopping smoking or weight loss programs.
- Performing coordination of care and case management.
- Conducting activities to improve the health or reduce the health care costs of our members. For example, we may use or share your information with others to help manage your health care. We may also talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- Managing our business and performing general administrative activities, such as customer service and resolving internal grievances and appeals.
- Conducting medical reviews, audits, fraud and abuse detection, and compliance and legal services.
- Conducting business planning and development, rating our risk, and determining our premium rates. However, we will not use your generic information for underwriting purposes.
- Reviewing the competence, qualifications, or performance of our network providers, and conducting training programs, accreditation, certification, licensing, credentialing and other quality assessment and improvement activities.
- **Business Associates:** We may share your information with others who help us conduct our business operations, provided they agree to keep your information confidential.

OTHER WAYS PRIME HEALTH CHOICE WILL USE OR SHARE INFORMATION

We may also use and share your information for the following other purposes:

- We may use or share your information with the employer or other health-plan sponsor through which you receive your health benefits. We will not share individually identifiable health information with your benefits plan unless they promise to keep it protected and use it only for purposes relating to the administration of your health benefits.
- We may share your information with a health plan, provider, or health care clearinghouse that participates with us in an organized health care arrangement. We will only share your information for health care operation activities associated with that arrangement.

- We may share your information with another health plan that provides or has provided coverage to you for payment purposes. We may also share your information with another health plan, provider in health care clearinghouse that has or had a relationship with you for the purpose of quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.
- We may share your information with a family member, friend, or other person who is assisting with your health care or payment for your health care. We may also share information about your location, general condition, or death to notify or help notify (including identifying and locating) a person involved with your care or to help with disaster-relief efforts. Before we share this information, we will provide you with an opportunity to object. If you are not present, or in the event of your incapacity or an emergency, we will share your information based on our professional judgment of whether the disclosure would be in your best interest.

STATE AND FEDERAL LAWS ON RELEASE OF HEALTH INFORMATION

There are also state and federal laws that allow or may require us to release your health information to others. We may share your information for the following reasons:

- We may report or share information with state and federal agencies that regulate the health care or health insurance system such as the U.S. Department of Health and Human Services, the New York State Insurance Department, and the New York State Department of Health.
- We may share information for public health and safety purposes. For example, we may report information to the extent necessary to avert an imminent threat to your safety or the health or safety of others. We may report information to the appropriate authorities if we have reasonable belief that you might be a victim of abuse, neglect, domestic violence, or other crimes.
- We may provide information to a court or administrative agency (for example, in response to a court order, search warrant, or subpoena).
- We may report information for certain law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.

-
- We may share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information with funeral directors as necessary to carry out their duties.
- We may use or share information for procurement, banking or transplantation of organs, eyes, or tissue.
- We may share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others, and to correctional institutions and in other law enforcement custodial situations.
- We may report information on job-related injuries because of requirements for your state worker compensation laws.
- Under certain circumstances, we may share information for purposes of research.

Certain types of especially sensitive health information, such as HIV-related, mental health and substance abuse treatment records, are subject to heightened protection under the law. If any state or federal law or regulation governing this type of sensitive information restricts us from using or sharing your information in any manner otherwise permitted under this Notice, we will follow the more restrictive law or regulation.

MEMBER AUTHORIZATION

If one of the preceding reasons does not apply, we must get your written authorization to use or disclose your health information. If you give us written authorization and change your mind, you may revoke your written authorization to release your health information. We cannot guarantee that the person to whom the information is provided will not re-disclose the information.

The authorization form describes the purpose for which the information is to be used, the time during which the authorization form will be in effect, and your right to revoke authorization at any time. The authorization form must be completed and signed by you or your duly authorized representative and returned to us before we will disclose any of your protected health information. You can obtain a copy of this form by calling the Customer Service phone number on the back of your ID card.

MEMBER RIGHTS

The following are your rights with respect to the privacy of your health information. If you would like to exercise any of the following rights, please contact us by calling the telephone number shown on the back of your ID card.

Restricting Information

- **You have the right to ask us to restrict** how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your request, we are not required to agree to these restrictions.

Member's Confidentiality

You have the right to ask to receive confidential communications of information if you believe that you would be endangered if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence). You can ask us to send the information to an alternative address or by alternative means, such as by fax. We may require that your request be in writing and you specify the alternative means or location, as well as the reason for your request. We will accommodate reasonable requests. Please be aware that the explanation of benefit statement (s) that the Plan issues to the contract holder or certificate holder may contain sufficient information to reveal that you obtained health care for which the Plan paid, even though you have asked that we communicate with you about your health care in confidence.

- **You have the right to inspect and obtain a copy** of information that we maintain about you in your designated record set. A "designated record set" is the group of records used by or for us to make benefit decisions about you. This can include enrollment, payment, claims, and case or medical management records. We may require that your request be in writing. We may charge a fee for copying information or preparing a summary or explanation of the information and in certain situations, we may deny your request to inspect or obtain a copy of your information.
- **You have the right to ask us to amend** information we maintain about you in your designated record set. We may require that your request be in writing and that you provide a reason for your request. We may deny your request for an amendment if we did not create the information that you want amended and the originator remains available or for certain reasons, if we deny your request, you may file a written statement in disagreement.

IMPORTANT INFORMATION ABOUT ADVANCED DIRECTIVES

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your Care Manager.

Information Available on Request

- Information regarding the structure and operation of Prime Health Choice LLC.
- Specific clinical review criteria relating to a particular health condition and other information that Prime Health Choice LLC considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- A recent copy of the Prime Health Choice LLC certified financial statement; and policies and procedures used by Prime Health Choice LLC to determine eligibility of a provider
- Prime Health Choice, LLC shall be in compliance with the requirements of 42 CFR § 438.3(j)(l) and 42 CFR Part 489 Subpart I, maintain written policies and procedures regarding Advance Directives and inform each Enrollee in writing at the time of enrollment of an individual's rights under State law to formulate Advance Directives and of the Prime Health Choice's policies regarding the implementation of such rights. Prime Health Choice, LLC shall include in such written notice to the Enrollee materials relating to Advance Directives and health care proxies as specified in 10 NYCRR §§ 98-1.14(f), 400.21 Part 98. The written information must reflect changes in State law as soon as possible, but no later than ninety (90) days after the effective date of the change.

- You have the right to make your own health care decisions. Sometimes, as a result of a serious accident or illness, that may not be possible. You can plan of time for such situations by preparing an Advance Directive that will help ensure that your health care wishes are followed. There are different types of Advance Directives:
- **Do Not Resuscitate (DNR) 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 (PCP) can provide a DNR order for your medical records. You can 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 NYS driver's license or non-driver ID card to let others know of and how you want to donate your organs.
- **Living Will**: You can give specific instructions about treatment in advance of situations where you may be unable to make important health care decisions on your own.

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 discrimination against providing medical care based on whether a person has an Advance Directive or not. For more information, please speak to your Care Manager or your Primary Care Provider. The Prime Health Choice, LLC enrollment packet will contain Advance Directive forms. You do not need to use a lawyer, but you may wish to speak with one about this important issue. You may change your mind at any time. Contact your Care Manager if you wish to make any changes.

- **Health Care Proxy:** This is a document that enables competent adults to protect their health care wishes by appointing someone they trust to decide about treatment on their behalf when they are unable to decide for themselves.

HEALTH CARE PROXY

APPOINTING YOUR HEALTH CARE AGENT IN NEW YORK STATE

The New York Health Care Proxy allows you to appoint someone you trust – for example, a family member or close friend-to make health care decisions for you if you lose the ability to make decisions yourself. By appointing a health care agent, you can make sure that health care providers follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, doctors, and other health care providers must follow your agent's decisions as if they were your own.

You may allow your agent to make all health care decisions or only certain ones. You may also give your agent instructions that he or she has to follow. This form can also be used to document your wishes or instructions with regard to organ and/or tissue donation.

ABOUT THE HEALTH CARE PROXY FORM

This is an important legal document before signing you should understand the following facts:

- This form gives the person you choose as your agent the authority to make all health care decisions for you, including the decision to remove or provide life-sustaining treatment, unless you say otherwise in this form. "Health Care" means any treatment, service, or procedure to diagnose or treat your physical or mental condition.
- Unless your agent reasonably knows your wishes about artificial nutrition and hydration (nourishment and water provided by a feeding tube or intravenous line), he or she will not be allowed to refuse or consent to those measures for you.
- Your agent will start making decisions for you when your doctor determines that you are not able to make health care decisions for yourself.
- You may write on this form example of the types of treatments that you would not desire and/or those treatments that you want to make sure you receive. The instructions may be used to limit the decision-making power of the agent. Your agent must follow your instructions when making decisions for you.
- You do not need a lawyer to fill out this form.
- You may choose any adult (18 years of age or older), including a family member or close friend, to be your agent. If you select a doctor as your agent, he or she will have to choose between acting as your agent or as your attending doctor, because a doctor cannot do both at the same time. Also, if you are a patient or resident of a hospital, nursing home or mental hygiene facility, there are special restrictions about naming

- someone who works for that facility as your agent. Ask staff at the facility to explain those restrictions.
- Before appointing someone as your health care agent, discuss it with him or her to make sure that he or she is willing to act as your agent. Tell the person you choose that he or she will be your health care agent. Discuss your health care wishes and this form with your agent. Be sure to give him or her, a signed copy. Your agent cannot be sued for health care decisions made in good faith.
- If you have named your spouse as your health care agent and you later become divorced or legally separated, your former spouse will no longer be your agent by law, unless you state otherwise. If you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.
- Even though you have signed this form, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped if you do not object, nor will your agent have any power to object.
- You may cancel the authority given to your agent by telling him or her or your health care provider orally or in writing.
- Appointing a health care agent is voluntary. No one can require you to appoint one.
- You may express your wishes or instructions regarding organ and/or tissue donation on the form.

Information Available on Request:

§ Information regarding the structure and operation of Prime Health Choice LLC;

§ Specific clinical review criteria relating to a particular health condition and other information that Prime Health Choice LLC considers when authorizing services.

§ Policies and procedures on protected health information.

§ Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.

§ Provider credentialing policies.

§ A recent copy of the Prime Health Choice LLC certified financial statement; and policies and procedures used by Prime Health Choice LLC to determine eligibility of a provider

FREQUENTLY ASKED QUESTIONS

Why should I Choose a Health Care Agent?

If you become unable, even temporarily, to make health care decisions, someone else must decide for you. Health care providers often look to family members for guidance. Family members may express what they think your wishes are related to a particular treatment. However, in New York State, only a health care agent you appoint has the legal authority to make treatment decisions if you are unable to decide for yourself. Appointing an agent lets you control your medical treatment by:

- Allowing your agent to make health care decisions on your behalf as you would want them decided.
- Choosing one person to make health care decisions because you think that person would make the best decisions.
- Choosing one person to avoid conflict or confusion among family members and/or significant others.

You may also appoint an alternate agent to take over if your first choice cannot make decisions for you.

Who Can Be A Health Care Agent?

Anyone 18 years of age or older can be health care agent. The person you are appointing as your agent or your alternate agent cannot sign as a witness on your Health Care Proxy form.

How Do I Appoint A Health Care Agent?

All competent adults, 18 years of age or older, can appoint a health care agent by signing a form called a Health Care Proxy. You do not need a lawyer or a notary, just two adult witnesses. Your agent cannot sign as a witness. You can use the form printed here, but you do not have to use this form.

When Would My Health Care Agent Begin to Make Health Care Decisions for Me?

Your health care agent would begin to make health care decisions after your doctor decides that you are not able to make your own health care decisions. As long as you are able to make health care decisions for yourself, you will have the right to do so.

What Decisions Can My Health Care Agent Make?

Unless you limit your health care agent's authority, your agent will be able to make any health care decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments, and decide that treatments should not be provided, in accordance with your wishes and interests.

However, your agent can only make decisions about artificial nutrition and hydration (nourishment and water provided by feeding tube or intravenous line) if he or she knows your wishes from what you have said or what you have written.

The Health Care Proxy form does not give your agent the power to make non-health care decisions for you such as financial decisions.

Why Do I need to Appoint A Health Care Agent If I am Young and Healthy?

Appointing a health care agent is a good idea even though you are not elderly or terminally ill. A health care agent can act on your behalf if you become even temporarily unable to make your own health care decisions (such as it might occur if you are under general anesthesia or have become comatose because of an accident). When you again become able to make your own health care decisions, your health care agent will no longer be authorized to act.

How Will My Health Care Agent Make Decisions?

Your agent must follow your wishes, as well as your moral and religious beliefs. You may write instructions on your Health Care Proxy form or simply discuss them with your agent.

How Will My Health Care Agent Know My Wishes?

Having an open and frank discussion about your wishes with your health care agent will put him or her in a better position to serve your interests. If your agent does not know your wishes or beliefs, your agent is legally required to act in your best interest. Because this is a major responsibility for the person you appoint as your health care agent, you should have a discussion with the person about what types of treatments you would or would not want under different types of circumstances, such as:

- Whether you would want life support initiated/continued or removed if you are in a permanent coma.
- Whether you would want treatments initiated/continued or removed if you have a terminal illness.
- Whether you would want artificial nutrition and hydration initiated/withheld, continued, or withdrawn, and under what types of circumstances.

Can My Health Care Agent Overrule My Wishes or Prior Treatment instructions?

No. your agent is obligated to make decisions based on your wishes. If you clearly expressed wishes, or gave treatment instructions, your agent has a duty to follow those wishes or instructions unless he or she has a good faith basis for believing that your wishes changed or do not apply to the circumstances.

Who will pay Attention To My Agent?

All hospitals, nursing homes, doctors and other health care providers are legally required to provide your health care agent with the same information that would be provided to you and to honor the decisions by your agent as if they were made by you. If a hospital or nursing home objects to some treatment options (such as removing certain treatment), they must tell you or your agent, BEFORE OR UPON admission, if reasonably possible.

What If My Health Care Agent Is Not Available When Decisions Must Be Made?

You may appoint an alternate agent to decide for you if your health care agent is unavailable, unable, or unwilling to act when decisions must be made. Otherwise, health care providers will make health care decisions for you that follow instructions you gave while you were still able to do so. Any instructions that you write on your Health Care Proxy form will guide health care providers under these circumstances.

What If I Change My Mind?

It is easy to cancel your Health Care proxy, to change the person you have chosen as your health care agent or to change any instructions or limitations you have included on the form. Simply fill out a new form. In addition, you may indicate that your Health Care Proxy expires on a specified date or if certain events occur. Otherwise, the Health Care Proxy will be valid indefinitely. If you choose your spouse as your health care agent or as your alternate, and you get divorced or legally separated, the appointment is automatically cancelled. However, if you would like your former spouse to remain your agent, you may note this on your current form and date it or complete a new form naming your former spouse.

Can My Health Care Agent Be Legally Liable for Decisions Made on My Behalf?

No. Your health care agent will not be liable for health care decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs of your care just because he or she is your agent.

Is A Health Care Proxy the Same as A Living Will?

No. A living will is a document that provides specific instructions about your health care decisions. You may put such instructions on your Health Care Proxy form. The Health Care Proxy allows you to choose someone you trust to make health care decisions on your behalf. Unlike a living will, A Health Care proxy does not require that you know in advance all the decisions that may arise.

Instead, your health care agent can interpret your wishes as medical circumstances change and can make decisions you could not have known would have to be made.

Where Should I Keep My Health Care Proxy Form After It Is Signed?

Give a copy to your agent, your doctor, your attorney and any other family members or close friends you want. Keep a copy in your wallet or purse, or with other important papers, but not in a location where no one can access it, like a safe deposit box. Bring a copy if you are admitted to the hospital, even for minor surgery, or if you undergo outpatient surgery. *Please do not send your Health Care Proxy to Prime Health Choice, LLC.*

May I Use the Health Care Proxy Form to Express My Wishes About Organ and/or Tissue Donation?

Yes. Use the optional organ and tissue donation section on the Health Care Proxy form. Be sure to have the section witnessed by two people and specify that your organs and/or tissue may be used for transplantation, research, or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

Failure to include your wishes and instructions on your Health Care Proxy form will not be taken to mean that you do not want to be an organ and/or tissue donor.

Can My Health Care Agent make Decisions for Me about Organ and/or Tissue Donation?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Who Can Consent to a Donation If I choose not To State My Wishes at This Time?

It is important to note your wishes about organ and/or tissue donation so that family members who will be approached about donation are aware of your wishes. However, New York law provides a list of individuals who are authorized to consent to organ and/or tissue donation on your behalf. They are listed in order of priority: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Health Care Proxy Form Instructions

Item (1)
Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2)
If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3)
Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4)
If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here, or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.
If you want to give your agent broad authority, you may do so right on the form. Simply write: *I have discussed my wishes with my health care agent and they know my wishes, including those about artificial nutrition and hydration.*
If you wish to make more specific instruction, you could say: If I become terminally ill, I do/do not want to receive the following types of treatments: if I am in a coma or have little conscious understanding, with no hope of recovery, then I do/do not want the following treatments:

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/do not want the following types of treatments: … I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below. This is not a complete list:

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Surgical procedures
- Dialysis
- Transplantation
- Blood transfusions
- Abortion

- Sterilization.

Item (5)
You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6)
You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals, in order of priority, to consent to an organ and/or tissue donation on your behalf; your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Item (7)
Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

Health Care Proxy

(1) I, _____ hereby appoint

_____

_____ as

my health care agent to make any and all health care decisions for me, except to the extent that I state other wise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) Optional: Alternate Agent

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

_____

_____

_____ as

my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely. (Optional: If you want this proxy to expire, state the date or conditions here.) This proxy shall expire (specify date or conditions):

_____

_____

_____

(4) Optional: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)* I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary)*:

_____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) Your Identification (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) Optional: Organ and/or Tissue Donation

I hereby make an anatomical gift, to be effective upon my death, of: *(check any that apply)*

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) Statement by Witnesses *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____ Date _____

Name of Witness 1

(print) _____

Name of Witness 2

(print) _____

Signature _____ Signature _____

Address _____ Address _____

MANAGED LONG -TERM CARE ENROLLEE RIGHTS

The following identifies, at a minimum, managed long term care demonstration Enrollee rights, and the language that must be used when communicating these rights to Potential Enrollees, Applicants and Enrollees in written material.

- 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 health care, 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, national 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.

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