

Hamaspik Medicare Choice 2026 Member Handbook



HAMASPIK, INC.

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WELCOME TO Hamaspik Medicare Choice MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to Hamaspik Medicare Choice Medicaid Advantage Plus (MAP) Program. The MAP Program is designed for people who have Medicare and Medicaid and who need health services 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 Hamaspik Medicare Choice covers since you are enrolled in the Hamaspik Medicare Choice MAP Program. It also tells you how to request a service, file a complaint or disenroll from Hamaspik Medicare Choice MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the Hamaspik Medicare Choice Medicare Evidence of Coverage. Keep this handbook with the Hamaspik Medicare Choice Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

Section I- HELP FROM Hamaspik Medicare Choice member services

You can call us anytime, 24 hours a day seven days a week, at the Hamaspik Medicare Choice member services numbers below.

There is someone to help you at Member Services:

7 days a week, from 8:00 am to 8:00 pm, October 1, 2025, through March 31, 2026. From April 1, 2026, through September 30, 2026, our Member Service team will be available Monday through Friday, 8:00 am to 8:00 pm. Call Member Services at 1-888-426-2774, TTY 711

You can receive information in another language, or in other formats if you have vision problems. Please call Member Services, and the staff will be able to assist you. These services are available at no cost to you.

Section II-ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you meet **all** of the following requirements:

- 1) Are age 18 or older,
- 2) Reside in the Plan's service area which includes the following counties:
 - Bronx
 - Dutchess
 - Kings (Brooklyn)

- Nassau
 - New York (Manhattan)
 - Orange
 - Putnam
 - Queens
 - Richmond (Staten Island)
 - Rockland
 - Sullivan
 - Ulster
 - Westchester
- 3) Have Medicaid,
 - 4) Have evidence of Medicare Part A & B coverage,
 - 5) Must enroll in Hamaspik Medicare Choice Medicare Advantage Dual Special Needs Plan
 - 6) Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety or you are permanently placed in a nursing home,
 - 7) Need at least one CBLTSS for more than 120 days and the following:
 - individuals with a diagnosis by a physician of Dementia or Alzheimer's and needs help with at least supervision with more than one activity of daily living (ADL); or
 - individuals who are assessed as needing at least limited assistance with physical maneuvering with more than two ADLs.

CBLTSS includes services provided in the home or community setting (any place of residence, either permanent or temporary, other than a hospital, skilled nursing home, or health related facility) as included in the MAP plan benefit package and provided by the MAP plan when medically necessary. CBLTSS services includes Private Duty Nursing, Skilled Nursing, Home Health Services, Personal Care Services*, Consumer Directed Personal Assistance Services, and Adult Day Health Care.

* Level 2 requires physical assistance with activities of daily living. Services such as housekeeping and shopping do not meet the need for level 2 services. [More information is available in Title 18 - 505.14.](#)

Note: Individuals enrolled in the MLTC program as of August 2025 will be granted MLTC Plan Legacy status and be assessed under previous criteria as long as they remain continuously enrolled. These MLTC Plan Legacy individuals will not be required to meet the Minimum Needs Requirements at reassessment.

You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave Hamaspik Medicare Choice.

The coverage explained in this handbook becomes effective on the effective date of your enrollment in Hamaspik Medicare Choice MAP Program. Enrollment in the MAP Program is voluntary.

New York Independent Assessor Program (NYIAP)- Initial Assessment Process

The NYIAP will conduct an initial assessment for individuals who have expressed an interest in enrolling in a Managed Long Term Care plan. 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 MLTC plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:
 - have a need for help with daily activities, **and**
 - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIAP 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 NYIAP will complete a clinical appointment and PO a few days later.

Annually, you, as a MLTC enrollee will then be reassessed by Hamaspik Medicare Choice, to ensure your needs still meet the MLTC Program Eligibility requirements.

Hamaspik Medicare Choice 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 twelve (12) hours per day on average, a separate review by the NYIAP 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 necessary medical documentation. If more information is needed, someone on the panel may ask to examine you and/or discuss your needs with you. The IRP will make a recommendation to Hamaspik Medicare Choice about whether the plan of care meets your needs.

Once NYIAP has completed the initial assessment steps and determined that you are eligible for MLTC, you can then choose which MLTC Care plan in which to enroll. Because you also are enrolled in Medicare for this same plan, you have chosen to combine your benefits and enroll in Hamaspik Medicare Choice.

If you are eligible to enroll, and interested in Hamaspik Medicare Choice, a Nurse from our Program will come to your home at a time that is convenient for you, or he/she may meet with you

“virtually” through an online app. If you wish, you may also have a family member or other 5 caregiver with you during the appointment. The Nurse will review your assessment in order to confirm that you are eligible to enroll and will work closely with you to develop your plan of care. We will share a written copy of your plan of care with you before you enroll, so you understand the services you will receive in the MAP plan.

Once you complete the Medicare enrollment, and we confirm with Medicare that you are eligible, we will also meet with you to complete the Medicaid enrollment documents. Hamaspik Medicare Choice will submit this information to Medicaid.

In most cases, your enrollment will be effective on the first day of the next month.

Hamaspik Medicare Choice may recommend denial of your enrollment within ten (10) calendar days of receiving an enrollment request, if we determine that you are not eligible, based on the criteria listed above, or if you do not provide the information that is needed in order to process your enrollment. If denial of your enrollment is recommended, it must be approved by Medicaid, and we will send you a notice that includes an explanation of the reason for denial. You will have an opportunity to appeal the denial. Please contact Member Services if you need more information. Note that Hamaspik Medicare Choice will not discriminate in the enrollment process based on your health status, any change in your health status, the services that you need, or the cost of your covered services.

If you enroll and then change your mind, you can withdraw your enrollment. Please contact Member Services to let us know. If you want to withdraw your enrollment, you must let us know by noon on the 25th day of the month before the effective date.

Plan Member (ID) Card

You will receive your Hamaspik Medicare Choice identification (ID) card within fourteen (14) days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact Hamaspik Medicare Choice’s at Member Services at 1-888-426-2774, TTY 711.

Behavioral Health Appointment Standards

Use the following list as the **appointment standards for our limits on how long you may have to wait after your request for a behavioral health appointment:**

- Initial appointment with an outpatient facility or clinic: 10 business days
- Initial appointment with a behavioral health care professional who is not employed by or contracted with an outpatient facility or clinic: 10 business days
- Follow-up visit after mental health/substance abuse emergency room (ER) or inpatient visit: 5 business days

- Non-urgent mental health or substance abuse visit: 5 business days

If you are unable to schedule a behavioral health appointment within the appointment wait times listed above, you, or your designee, may submit an access complaint to Hamaspik Medicare Choice by telephone, 1-888-426-2774 and in writing to Hamaspik Medicare Choice at 775 North Main Street, Spring Valley, NY 10977 to resolve this issue.

If we are unable to locate a plan participating provider that can treat your behavioral health condition, you can receive a referral to a qualified out-of-network provider who can.

Behavioral Health Access Complaint

If you are unable to schedule a behavioral health appointment and if you submit a behavioral health access complaint, Hamaspik Medicare Choice must provide you with the name and contact information of a provider that can treat your behavioral health condition. Hamaspik Medicare Choice must provide this information within three (3) business days after receiving your complaint.

Section III - SERVICES COVERED BY THE Hamaspik Medicare Choice MAP PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive, including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests, are covered by Medicare and are described in the Hamaspik Medicare Choice Medicare Evidence of Coverage. Chapter 3 of the Hamaspik Medicare Choice Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or urgent care situation. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Chapter 4 of Hamaspik Medicare Choice Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined Hamaspik Medicare Choice, and you have Medicaid, Hamaspik Medicare Choice will pay these amounts on your behalf. You do not have to pay these deductibles and co-payments except for those that apply to some pharmacy items.

If there is a monthly premium for benefits (see Chapter 1 of the Hamaspik Medicare Choice Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a Care Manager who is a health care professional usually a nurse or a social worker. Your

Care Manager will work with you and your doctor to decide the services you need and develop a care plan. Your Care Manager will also arrange appointments for any services you need and arrange for transportation to those services.

Additional Covered Services

Because you have Medicaid and qualify for the MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in Hamaspik Medicare Choice network. If you cannot find a provider in our Plan, to provide a service covered in the Hamaspik Medicare Choice benefit package, please contact Member Services or your Care Manager to assist you in submitting a request for medical necessity review/coverage determination

- ***Adult Day Health Care***
 - *Adult day care programs provide a structured program in a community setting to help you socialize with other Members. Adult day health care programs include nursing, rehabilitation therapies, social workers, personal care, assistance with medications, and nutrition services in a safe setting. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.*

- ***Audiology***
 - *This includes a range of services and products that are covered for a disability caused by the loss or impairment of hearing. Services include: audiology services (examinations and testing, hearing aid evaluations and hearing aid prescriptions); hearing aid selection, fitting, and hearing aid checks following dispensing; hearing aid products (hearing aids, earmolds, and special fittings); and hearing aid repairs and replacement.*

- ***Consumer Directed Personal Assistance Services***
 - *If you choose to receive CDPAS services, you will be able to hire and supervise your own worker to provide assistance with your daily needs. Your worker could be a family member, friend, or another person who you select. In order to choose this service, your doctor will have to certify that you are able to supervise your worker. Your worker will have to register with Public Partnerships Ltd. (PPL) in order to submit timesheets and receive paychecks. Please talk to your care manager if you are interested in CDPAS services. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.*

- ***Dental***
 - *Includes but not limited to: routine exams, preventive and therapeutic dental care,*

dentures and supplies. Hamaspik Medicare Choice is now covering crowns and root canals in certain circumstances so that you can keep more natural teeth. In addition, replacement dentures and implants will only need a recommendation from your dentist to determine if they are necessary. This will make it easier for you to access these dental services. Basic dental care does not require authorization. Some restorative services require authorization.

- ***Durable Medical Equipment***
 - *Durable medical equipment includes devices and equipment that can be repeatedly used for a period of time, and are primarily and customarily used for medical purposes. Most of these services require authorization from Hamaspik Medicare Choice. Please contact Hamaspik Medicare Choice Durable Medical Equipment Team at 855-552-4642 ext 612 for more information.*

- ***Emergency Transportation***
 - *Covered ambulance services in an emergency include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care, when they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health. Emergency transportation does not require prior authorization. All Non-Emergency ambulance transportation requires review for prior authorization.*

- ***Home Delivered Meals and/or meals in a group setting such as a day care***
 - *You may choose to receive home delivered meals, or meals in a day care program as a substitute for some personal care services or CDPAS services. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.*

- ***Home Health Care Services Not Covered by Medicare including nursing, home health aide, occupational, physical and speech therapies***
 - *You may need additional nursing, medical social services, occupational, physical and speech therapies, and/or home health aide services that are not covered by Medicare. If you need these services, they will be provided by a home care agency based on "doctor's orders" from your physician. All home health care services must be authorized by Hamaspik Medicare Choice in your care plan.*
 - *Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit. You are eligible for inpatient mental health care beyond the 190-day lifetime limit of your Medicare coverage. Please see the Benefits Chart in Chapter 4 of your Medicare Evidence of Coverage for instructions regarding how to obtain these services. Except in an emergency, these services must be authorized by Hamaspik Medicare Choice.*

- ***Medical Social Services***
 - *A Social Worker or other professional may work with you to help you with your psychosocial needs, and may help you to access other types of supportive services. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.*

- **Medical Supplies**
 - *You are covered for medical and surgical supplies (including Hearing Aid Batteries), which will be delivered to your home. These services must be ordered by your doctor in most cases (except for hearing aid batteries). If you need these services, they must be authorized by Hamaspik Medicare Choice.*
- **Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)**
 - *Nursing Home Care is covered for individuals who are considered to be permanently placed in a nursing home, provided you are eligible for institutional Medicaid coverage.*
- **Nutrition**
 - *Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition.*
 - *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.*
- **Optometry**
 - *Services provided by optometrists, ophthalmologists, and ophthalmic dispensers. Services include examinations for diagnosis and treatment of visual defects and eye disease, as well as routine eye exams. Coverage includes eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes, low vision aids, and low vision services. Coverage also includes the repair or replacement of parts for eyeglasses.*
- **Outpatient Rehabilitation**
 - *Physical therapy, occupational therapy and speech/language therapy are available in an outpatient rehabilitation program. These services must be ordered by your doctor and authorized by Hamaspik Medicare Choice*
- **Personal Care (such as assistance with bathing, eating, dressing, toileting, and walking)**
 - **Consumer Directed Personal Assistance Program**

- **Statewide Fiscal Intermediary**

As of April 1, 2025, members must contact Public Partnerships Ltd. (PPL) to register

Public Partnerships Ltd. (PPL)
 Support Center: 1-833-247-5346 or TTY: 1-833-204-9042.
 Website: pplfirst.com/cdpap

The consumer, or a designated representative, chooses their personal assistant(s). The consumer is responsible for hiring, training, and supervising the assistant(s).

The services can include assistance with personal care, such as bathing and dressing, as well as skilled nursing services.

Public Partnerships Ltd: Statewide Fiscal Intermediary (SFI) handles administrative tasks like payroll, taxes, and billing, allowing the consumer to focus on the care itself.

Please contact your care manager or member services department if you require assistance registering with PPL for CDPAS services. Our team can assist you with connecting you to PPL directly *or* with a PPL facilitator.

CDPAP facilitators are community-based organizations located throughout New York State who can help you transition to PPL as the statewide fiscal intermediary and provide ongoing customer service and EVV support. CDPAP Facilitators can also be found

<https://pplfirst.com/cdpap-facilitators/>

- ***Personal Emergency Response System (PERS)***
PERS are electronic devices that can be installed in your home or worn on a pendant. A PERS device allows you to call for help in an emergency. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.
- ***Private Duty Nursing***
A private duty nurse may provide care in your home if you need this level of care. If you need these services, they will be provided by a home care agency based on “doctor’s orders” from your physician. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.
- ***Prosthetics and Orthotics***
Prosthetic devices are used to replace all or part of a body part or function. These include but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement if needed.

Orthotic appliances (such as a brace or splint) are used for supporting, immobilizing, or treating muscles, joints, or bones that are weak, deformed, or injured. They are used over a period of time, and are usually fitted, designed or fashioned for a particular individual's use.

Orthopedic footwear includes shoes that are specifically designed to support or accommodate the mechanics and structure of the foot, ankle and leg.

If you need these services, they must be authorized by Hamaspik Medicare Choice.

- ***Social Day Care***
Social day care programs provide a structured program in a community setting to help you socialize with other Members, and provide you with some personal care and nutrition services in a safe setting. If you need these services, they must be authorized by Hamaspik Medicare Choice in your care plan.

- ***Social/Environmental Supports (such as chore services, home modifications or respite)***
Other services (such as chore services, home modifications, exterminators, or respite care) are also available based on your needs. These services are customized based on your individual needs, and they must be authorized by Hamaspik Medicare Choice.

Health Related Social Needs (HRSN) Screening and Services

As of **January 1, 2025**, you can receive screening and referral to existing local, state and federal services through regional Social Care Networks (SCNs). If you are eligible, these local groups can connect you to services in your community that help with housing, transportation, education, employment, and care management at no cost to you.

- After screening through this SCN, you and any interested member(s) in your household can meet with a Social Care Navigator who can confirm eligibility for services that can help with individual health and well-being. They may ask you or members in your household for supporting documentation to determine where extra support may be needed.
- If you or any member(s) in your household qualify for services, the Social Care Navigator can work with you to get the support needed. You may qualify for more than one service, depending on individual eligibility. These services include:
 - Housing and utilities support:
 - Installing home modifications like ramps, handrails, grab bars, pathways, electric door openers, widening of doorways, door and cabinet handles, bathroom facilities, kitchen cabinet or sinks, and non-skid surfaces to make your home accessible and safe.
 - Mold, pest remediation, and asthma remediation services.
 - Providing an air conditioner, heater, humidifier, or dehumidifier to help improve ventilation in your home.
 - Providing small refrigeration units needed for medical treatment.
 - Helping you find and apply for safe and stable housing in the community which may include assistance with rent and utilities.

NOTE: Some housing services may be covered by your plan. Therefore, some housing services will require coordination between the Social Care Navigator and your health plan's care manager.

- Transportation services:
 - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.

- Care management services:
 - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
 - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with an SCN in your area:

1. You may call the health plan’s member services 1-888-426-2774 TTY 711 and we will connect you to a SCN in your area
2. You may call the SCN within your county and request a screening or more information. See the SCN contact information in the chart below.
3. You may also visit their website to begin a self screening

Once connected with the SCN, a Social Care Navigator will confirm your eligibility by asking questions, requesting supporting documentation (if necessary), tell you more about eligible services, and help you get connected to them.

SCN	Counties	Phone number
Health Equity Alliance of Long Island	Nassau	516-505-4434
	https://healiny.org/	
Hudson Valley Care Coalition, Inc.	Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester	800-768-5080
	https://hudsonvalleycare.org/services/hudson-valleys-social-care-network/	
Public Health Solutions	Manhattan, Queens, Brooklyn	888-755-5045
	https://www.wholeyou.nyc/	
Staten Island Performing Provider System	Richmond	917-830-1140
	https://statenislandpps.org/social-care-network/	
Somos Healthcare Providers, Inc.	Bronx	833-SOMOSNY (833-766-6769)
	https://www.somoscommunitycare.org/social-care-network/	

Covered Behavioral Health (Mental Health and Addiction) Services

Adult Outpatient Mental Health Care

- **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

Adult Outpatient Rehabilitative Mental Health Care

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

Adult Outpatient Rehabilitative Mental Health And Addiction Services For Members Who Meet Clinical Requirements. These are also known as CORE.

Community Oriented Recovery and Empowerment (CORE) Services: Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer someone, or self-refer, to CORE Services.

- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources.
- **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment.
- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.
- **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
 - live with health challenges and be independent
 - help you make decisions about your own recovery, **and**

- find natural supports and resources.

Adult Mental Health Crisis Services

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.
- **Crisis Residential Programs:** A short term residence that provides 24 hours per day services for up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support your return to your community.

Adult Outpatient Addiction Services

Opioid Treatment Centers (OTP) are Office of Addiction Services and Supports certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

Adult Residential Addiction Services

Residential Services are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

Adult Inpatient Addiction Rehabilitation Services

State Operated Addiction Treatment Center's (ATC) provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.

Inpatient Addiction Rehabilitation programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.

Inpatient Medically Supervised Detox programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

Telehealth

You can receive some services through telehealth when appropriate. You may receive telehealth services through eConsults or electronic consultations which are communications between your doctor and specialists. It is your choice if you receive services in person or through telehealth. If you have additional questions on telehealth, please contact your Care Manager.

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 Service

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

If you are hospitalized, a family member or other caregiver should contact Hamaspik Medicare 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 Hamaspik Medicare Choice so that we may work with them to plan your care upon discharge from the hospital.

Transitional Care Procedures

New enrollees in Hamaspik Medicare Choice may continue an existing person-centered service plan for a transitional period of up to ninety (90) days from enrollment or until a new person-centered service plan is agreed upon between the new Enrollee and Hamaspik Medicare Choice, whichever is first.

Additionally, new enrollees in Hamaspik Medicare Choice may continue an ongoing course of treatment for a transitional period of up to ninety (90) days from enrollment with a non-network health care provider if the provider accepts payment at the Plan rate, adheres to Hamaspik Medicare Choice quality assurance and other policies, and provides medical information about the care to the 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

Money Follows the Person (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 and
- Have health needs that can be met through services in the 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, and/or
- 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.

Section IV- MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that Hamaspik Medicare Choice 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 Benefit Card. Call Member services at 1-888-426-2774, TTY 711 if you have a question about whether a benefit is covered by Hamaspik Medicare Choice or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy:

Most prescription drugs are covered by Hamaspik Medicare Choice Medicare Part D as described in section 6 of the Hamaspik Medicare Choice Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Hamaspik Medicare Choice Medicare Part D. Medicaid may also cover drugs that we deny.

The services listed below are services available through regular Medicaid:

Certain Mental Health Services, including:

- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of Office of Mental Health (OMH) Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment
- Office of Addiction Services and Supports (OASAS) Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)

- OMH Residential Treatment Facility (RTF)

For MAP enrollees up to the age of 21:

- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community Based Services (HCBS)

Certain Intellectual Disability 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:

- Directly Observed Therapy for TB (Tuberculosis)
- Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria

Family Planning

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

Non-Emergency Transportation

- Covered under regular Medicaid and arranged by the Statewide Transportation Broker, with the exception of Social Adult Daycare (SADC) programs. SADC providers are responsible for providing transportation to and from their programs for members.

SERVICES NOT COVERED BY Hamaspik Medicare Choice OR MEDICAID

- You must pay for services that are not covered by Hamaspik Medicare 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 Hamaspik Medicare Choice or Medicaid are: Cosmetic surgery, if not medically needed
- Personal and comfort items
- Services from a provider that is not part of the plan outside of a medical emergency (unless Hamaspik Medicare Choice authorizes you to see that provider)

If you have any questions, call Hamaspik Medicare Choice member services at 1-888-426-2774, TTY 711.

Section V- SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and also get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will use one process for both your Medicare and/or Medicaid benefits. This is sometimes called an “integrated process” because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 23 for more information on the External Appeals process.

Section 1: Service Authorization Request (also known as Coverage Decision Request)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you must

You or your provider may call Hamaspik Medicare Choice member services at our toll-free number: 1-888-426-2774 or send your request in writing to

Hamaspik Medicare Choice
775 North Main Street
Spring Valley, NY 10977

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

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from Hamaspik Medicare Choice before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

- Home health care (including nursing, rehabilitation therapies, social work, and home health aide services)
- Personal care
- Consumer directed personal assistance services (CDPAS)
- Adult day health care
- Social adult day care
- DME (including Medical/Surgical Supplies, Enteral and Parenteral Formula, Hearing Aid, Batteries, Prosthetics, Orthotics, and Orthopedic Footwear)
- Personal emergency response system (PERS)
- Physical therapy, occupational therapy, or speech therapy, provided in an outpatient setting
- Hearing aids and related products
- Respiratory therapy

- Nutrition services
- Private duty nursing
- Home delivered meals, or meals in a congregate setting
- Social and environmental supports

See Chapter 4 of your Medicare Evidence of Coverage for more information about the services that require prior authorization.

Concurrent Review

You can also ask Hamaspik Medicare Choice to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review

Sometimes we will do a review on the care you are 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 health plan has a review team to be sure you get the services you qualify for. Doctors and nurses are on the review team. Their job is to be sure the treatment or services you asked for are 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 you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

After we get your request, we will review it under either a **standard** or a **fast-track** process. You or your provider can ask for a fast-track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast-track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast-track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your requested amount. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process

Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item, treatment, or service unless we have agreed to use the fast-track deadlines.

- A **standard review** for a prior authorization request means we will give you an answer within three (3) workdays of when we have all the information we need, but no later than **seven (7) calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 workday of when we have all the information we need but will give you an answer no later than seven (7) calendar days after we get your request.
- **We can take up to fourteen (14) more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than fourteen (14) days from the day we asked for more information.
- If you believe we should **not** take extra days, you can file a **fast complaint**. When you file a **fast complaint**, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within seven (7) calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our answer is yes to part or all of what you asked for**, we will authorize the service, or treatment, 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 an Appeal Decision Notice that explains why we said no. More information about how to appeal this decision can be found in Section 2: Level 1 Appeals.

Fast Track Process

If your health requires it, ask us to give you a **fast service authorization**.

- A **fast review** of a prior authorization request means we will give you an answer within 1 workday of when we have all the information, we need but no later than 72 hours from when you made your request to us.
- We can take **up to fourteen (14) more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest.
- We will make a decision as quickly as we can when we receive the necessary information, but no later than fourteen (14) days from the day we asked for more information.

- If you believe we should not take extra days, **you can file a fast complaint**. For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan, below, for more information. We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal. To get a **fast service authorization**, you must meet two requirements:
 1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a **fast service authorization** if your request is about payment for medical care, you already got.)
 2. Using the standard deadlines could cause serious harm to your life or health or hurt your ability to function.

If your provider tells us that your health requires a fast service authorization, we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider's support, we will decide whether your health requires that we give you a **fast service authorization**.

If we decide that your medical condition does not meet the requirements for a **fast service authorization**, we will send you a letter that says so (and we will use the standard deadlines instead).

- This letter will tell you that if your provider asks for the **fast service authorization**, we will automatically give a **fast service authorization**.
- The letter will also tell how you can file a **fast complaint** about our decision to give you a standard service authorization instead of the fast service authorization you asked for.

(For more information about the process for making complaints, including fast complaints, see Section 4: What To Do If You Have A Complaint About Our Plan later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us within these timeframes, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If we are changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are reviewing care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending.** For more information about these rights, refer to Chapter 9 of the Hamaspik Medicare Choice Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care

If we say no to your request for coverage for a medical item or service, you can decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- Hamaspik Medicare Choice can also explain the complaints and appeals processes available to you depending on your complaint. You can call Hamaspik Medicare Choice member services at 1-888-426-2774 to get more information on your rights and the options available to you.

At any time in the process, 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.

Section 2: Level 1 Appeals (also known as a Plan Level Appeal)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1 of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice.

You can file a Level 1 Appeal:

If you are unhappy with a decision Hamaspik Medicare Choice makes, you can file an appeal. This is called a Level 1 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 1 appeal on any decision Hamaspik Medicare Choice makes.

Aid to continue while appealing a decision about your care

If Hamaspik Medicare Choice reduces, suspends, or stops a service you are getting now, you may be able to continue the service while you wait for a Level 1 appeal determination.

You must ask for a Level 1 appeal:

- **Within ten (10) days from being told that your care is changing, or**
- **By the date the change in service is scheduled to occur, whichever is later.**

If your Level 1 appeal results in another denial, you will not have to pay for the cost of any continued benefits that you receive.

If you are unhappy with your Level 1 appeal decision, you can appeal again. This is called a Level 2 appeal. Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a Level 2 appeal on any decision Hamaspik Medicare Choice makes.

Aid to continue while waiting for a Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing determination. Continuation of benefits is only available if Hamaspik Medicare Choice reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing:

- **Within ten (10) days from the date of the Appeal Decision letter, or**
- **By the date the change in services is scheduled to occur, whichever is later.**

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

If you are unhappy with the Level 2 appeal decision for a service covered by Medicare, you may have other appeal rights options. For more information about additional appeals rights options, see Chapter 9 of your Medicare Advantage D-SNP EOC or call Member Services.

Section 3: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**.

You can ask New York State (the State) for an independent **external appeal** if our Plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary, or

- experimental or investigational, or
- not different from care you can get in the Plan's network, or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the Plan or the State make the decision. These reviewers are qualified people approved by the State. The service must be in the Plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the State:

- You must file a Level 1 appeal with the Plan and get the Plan's Appeal Decision Notice:
- or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**
 - You and the Plan may agree to skip the Plan's appeals process and go directly to External Appeal; **or**
 - You can prove the Plan did not follow the rules correctly when processing your Level 1 appeal.

You have **four (4) months** after you get the Plan's **Appeal Decision Notice** to ask for an External Appeal. If you and the Plan agreed to skip the Plan's appeals process, then you must ask for the External Appeal within four (4) months of when you made that agreement.

To ask for an External Appeal fill out an application and send it to the Department of Financial Services.

- You can call Hamaspik Medicare Choice member services at Member Services at 1-888-426-2774, TTY 711 if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov .
- Contact the Health Plan at Member Services at 1-888-426-2774, TTY 711.

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five workdays) may be needed. The reviewer will tell you and the Plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the Plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, 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.

Section 4: What To Do If You Have A Complaint About Our Plan

Information in this section applies to **all** of your Medicare and Medicaid benefits, except Medicare Part D. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our Plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Hamaspik Medicare Choice member services at 1-888-426-2774, TTY 711 or write to Hamaspik Medicare Choice Member Services. The formal name for making a complaint is filing a grievance.

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling** Hamaspik Medicare Choice Member Services **is the first step.** If there is anything else you need to do, Hamaspik Medicare Choice Member Services will let you know.

October 1st through March 31st: Seven Days per week, 8:00 am to 8:00 pm
Call 888-426-2774. TTY users, call 711.

April 1st through September 30th: Monday through Friday, 8:00 am to 8:00 pm
Call 888-426-2774. TTY users, call 711.

- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- When you write to us, please tell us as much as you can about your complaint, including the date and time of the problem, the provider (if your complaint is about a provider), and a detailed description of what happened. We will then reach out to you to discuss your complaint and we will investigate it.
- **Whether you call or write, you should contact Hamaspik Medicare Choice Member Services right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- We answer complaints within thirty (30) calendar days.
- If you are making a complaint because we denied your request for a fast service authorization or a fast appeal, we will automatically give you a fast complaint. If you have a fast complaint, it means we will give you an answer within 24 hours.
- If we need more information and the delay is in your best interest or if you ask for more time, we can take up to fourteen (14) more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:
 - If you asked us to give you a fast service authorization or a fast appeal and we said, we will not.
 - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
 - When a service authorization we made is reviewed and we are told that we must

cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

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

How to make a complaint appeal:

- If you are not satisfied with what we decide you have sixty (60) workdays after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- You must make the complaint appeal in writing.
 - If you make an appeal by phone, you must follow it up in writing.
 - After your call, we will send you a form that summarizes your phone appeal.
 - If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal:

After we get your complaint appeal, we will send you a letter within fifteen (15) workdays. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within thirty (30) workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in two (2) workdays of when we have all the information. We will give you the reasons for our decision and our clinical rationale if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

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 call ICAN to get free, independent advice about your coverage, complaint, and appeal options. They can help you manage the appeal process.

ICAN can also provide support before you enroll in a MLTC plan like Hamaspik Medicare Choice. This support includes unbiased health plan choice counseling and general plan related information.

Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor, New York, New York 10017
Web: www.icannys.org | Email: ican@cssny.org
Phone: 1-844-614-8800 (TTY Relay Service: 711)
9:00 am – 5:00 pm, Monday –Friday

Through the ICAN website, you can chat with a live counselor or submit a request for one to call you back.

Section VI- DISENROLLMENT FROM Hamaspik Medicare Choice MAP PROGRAM

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

- High utilization of covered medical services, an existing condition or a change in the Enrollee's health, or
- diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

You Can Choose to Voluntary Disenroll

You can ask to leave the Hamaspik Medicare Choice, MAP PROGRAM at any time for any reason.

To request disenrollment, call our member services at 1-888-426-2774, TTY 711. It could take up to six (6) weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC Plan or Home and Community Based

Waiver program, in order to continue to receive CBLTSS services.

You Will Have to Leave Hamaspik Medicare Choice, MAP Program if:

- You no longer are enrolled in Hamaspik Medicare Choice for your Medicare coverage,
- You no longer are Medicaid eligible,
- You need nursing home care, but are not eligible for institutional Medicaid,
- You are out of the Plan's service area for more than thirty (30) consecutive days,
- You permanently move out of Hamaspik Medicare Choice service area,
- You are a MLTC Legacy Status Enrollee and you no longer eligible for nursing home level of care as determined using the CHA, unless the termination of the services provided by the Plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period,
- At the point of any reassessment while living in the community, you are determined to no longer meet the Minimum Needs ADL requirement,
- You have not received one of the CBLTSS services such as adult day health care, private duty nursing, home health aide services, CDPAS, or services in the home including personal care services (Level 2), nursing services or therapies. Please note that Social Adult Day Care services alone do not qualify you for continued enrollment,
- You join a Home and Community Based Services waiver program, or become a resident of an Office for People with Developmental Disabilities residential program,
- You become a resident of an OMH or OASAS residential program (that is not a MAP plan covered benefit) for forty-five (45) consecutive days or longer, or
- You refused to complete a required reassessment.

We May Ask You to Leave the Hamaspik Medicare Choice, MAP Program if:

- You or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the Plan's ability to furnish services.
- You knowingly provide fraudulent information on an enrollment form, or you permit abuse of an enrollment card in the MAP Program;
- You fail to complete and submit any necessary consent or release; or
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services (LDSS), owed to the Plan as spenddown/surplus within thirty (30) days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, Hamaspik Medicare Choice will obtain the approval of New York Medicaid Choice (NYMC), or an entity designated by the State to notify you of the intent to disenroll. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need CBLTSS, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services. Upon re-enrollment in the MAP Program, you may need to be assessed by NYIAP again.

Section VII- CULTURAL AND LINGUISTIC COMPETENCY

Hamaspik Medicare Choice 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 enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Section VIII- MEMBER RIGHTS AND RESPONSIBILITIES

Hamaspik Medicare Choice 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 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 gender, 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 request a fair hearing through the Office of Administrative Hearings and/or a New York State External Appeal, where appropriate.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- You have the responsibility to receive covered services through Hamaspik Medicare Choice.
- You have the responsibility to use Hamaspik Medicare Choice network providers for these covered services, to the extent network providers are available.
- You have the responsibility to obtain prior authorization for covered services, except for pre-approved covered services or in emergencies.
- You have the responsibility to see by your physician if a change in your health status occurs.
- You have the responsibility to share complete and accurate health information with your health care providers.
- You have the responsibility to inform Hamaspik Medicare Choice staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- You have the responsibility to follow the plan of care recommended by the Hamaspik Medicare Choice staff (with your input).
- You have the responsibility to cooperate with and be respectful with the Hamaspik Medicare Choice staff and not discriminate against Hamaspik Medicare Choice staff because of race, color, national origin, religion, gender, age, mental or physical ability, sexual orientation, or marital status.
- You have the responsibility to notify Hamaspik Medicare Choice within two business days of receiving non-covered or non-pre-approved services.
- You have the responsibility to notify your Hamaspik Medicare Choice health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- You have the responsibility to inform Hamaspik Medicare Choice before permanently moving out of the service area, or of any lengthy absence from the service area.

- You have the responsibility for the consequences of your actions if you refuse treatment or do not follow the instructions of your caregiver.
- You have the responsibility to meet your financial obligations.

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 Hamaspik Medicare Choice.
- Specific clinical review criteria relating to a particular health condition and other information that Hamaspik Medicare Choice 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 Hamaspik Medicare Choice certified financial statement; and policies and procedures used by Hamaspik Medicare Choice to determine eligibility of a provider.
- Written information (including plan documents and notices) in a language other than English, or in a format for people with hearing impairments or vision impairments (such as large print or Braille). To request your information in a different language or format, or to request any of the information listed above, please call Member Services at 888-426-2774. (TTY users, call 711

Electronic Notice Option

Hamaspik Medicare Choice and our vendors can send you notices about service authorizations,

plan appeals, complaints and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices to you by email.

If you want to get these notices electronically, you must ask us. To ask for electronic notices contact us by phone, email, fax or mail:

Phone.....	1-888-426-2774
Email.....	info@hamaspik.com
Fax.....	845-503-0999
Mail.....	775 North Main Street Spring Valley, NY 10977

When you contact us, you must:

- Tell us how you want to get notices that are normally sent by mail,
- Tell us how you want to get notices that are normally made by phone call, and
- Give us your contact information (mobile phone number, email address, fax number, etc.).

Hamaspik Medicare Choice will let you know by mail that you have asked to get notices electronically.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-888-426-2774 TTY 711.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-888-426-2774 TTY 711	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 。1-888-426-2774 TTY 711	Chinese
1-888-426-2774 TTY ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم .711	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-888-426-2774 TTY 711 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-888-426-2774 TTY 711.	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-888-426-2774 TTY 711.	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-888-426-2774 TTY 711.	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-888-426-2774 TTY 711.	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. 1-888-426-2774 TTY 711 רופט	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-888-426-2774 TTY 711.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-888-426-2774 TTY 711	Tagalog
মনোনে গোগোমুনযে ভাষা সহায়তা পরিনষবা এবং অতোতো সোহো আপোঁ জে উপষদ্ধা 1-888-426-2774 TTY 711এ ফোঁ কর।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-888-426-2774 TTY 711.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-888-426-2774 TTY 711	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بال معوضہ دستیاب ہیں۔ کال کریں 1-888-426-2744 TTY 711۔	Urdu