GUILDNET[SM]

GuildNet Gold

A Medicare + Medicaid Comprehensive Health Plan

MEMBER HANDBOOK

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GuildNet[SM]
15 West 65th Street
New York, NY 10023-6601
Phone: 800-932-4703
800-662-1220 TTY/TTD
Mon.-Fri. 8AM-8PM

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WELCOME TO GUILDNET GOLD

Welcome to GuildNet Gold!

GuildNet Gold is designed for people who have Medicare and Medicaid, and who need long-term care services, medical care, and environmental and social supports in order to live in their home and community safely, for as long as possible. Some examples of what GuildNet Gold offers are: skilled nursing care in your home, personal care, visits to your doctors, and prescription drugs. We also offer you ways to make your home safe, and your life easier.

As a member of GuildNet Gold, you will get a full benefit package consisting of the services that you would normally get from regular Medicare, including Part D prescription drug coverage, and most services that you would normally get from Medicaid fee-for-service. Plus, you can get some extra services like nutritional training, smoking cessation, and respite for your family and caregivers.

One of the things that makes GuildNet Gold different is that you can keep the doctors you see now, including the specialists that you go to. You do not need a referral to see these doctors, and you don't need prior authorization.

As a member of GuildNet Gold, you may be able to take advantage of the social supports that we offer. You may be able to go to a Social Day Center, or an Adult Day Health Care Center. At an Adult Day Health Care Center, you can socialize, as well as get medical care. At both of these Centers, you can participate in activities, and get meals and snacks. GuildNet Gold will arrange transportation to and from the Center.

A great thing about joining GuildNet Gold is that you **do not have any CO-PAYMENTS,** except for prescription drugs copayments.

Probably, the best thing about GuildNet Gold is that, within days of joining our program, you will have a Case Manager assigned to you. This person will help you every step of the way to get the care that you need. Your Case Manager will work with you, your family, and providers, to develop a plan of care that meets your health care needs. Your plan of care will be reviewed on a regular basis.

Your Case Manager will coordinate the services in your Care Plan for you, help you select providers, and arrange for transportation to and from appointments. You can always call your Case Manager to help you.

If you need to get in touch with your Case Manager or anyone else at GuildNet Gold, you can call us at the Member Services number below:

1-800-932-4703
TTY Number 1-800-662-1220
Monday through Friday 8:00 am to 8:00 pm

Member Service Number 1-800-932-4703
TTY Number 1-800-662-1220

WHAT THIS HANDBOOK IS FOR

This handbook tells you about the benefits that you get when you join GuildNet Gold. Along with other things, this handbook tells you how to join GuildNet Gold.

This handbook and your Evidence of Coverage should be kept together. These two documents will give you a full picture of your GuildNet Gold benefits, and how to get them.

OUR UNIQUE PLAN

You Do Not Have To Change Doctors

When you join GuildNet Gold, you do not have to change your doctors. However, your doctor must be willing to participate in your care plan, in order for you to keep him or her.

Network Providers

Using network providers is always the best thing to do because it makes it easier for your Case Manager to coordinate your care, and to develop a plan of care that meets your needs, in the best possible way.

GuildNet Gold allows you to go to out-of-network providers for services that you used to get using your Medicare card. *(See the "Covered Services" section of this Member Handbook.*) In this Member Handbook, we may refer to these services as services that you used to get through regular Medicare.

You have to use Network Providers to get most of the services that you used to get using your Medicaid card. (* See Covered Services Section of this Member Handbook.) In this Member Handbook we may refer to these services as services that you used to get through Medicaid fee- for-service.

You Do Not Need a Referral or Prior Authorization to See Your Doctors or To Receive Many Services

You do not need a referral or prior authorization, to see your doctors, or to receive many services. However, there are certain services that do require prior authorization. See the *Covered Services Section* of this Handbook for further information.

World Wide Emergency

GuildNet Gold covers **World Wide Emergency Care**. For more information see the ***"Accessing Services in Special Situations"*** section of this Member Handbook.

Out of Area Care Anywhere In the United States

GuildNet Gold covers out of area care anywhere in the United States. If the service that you want is not vital to your health and well being, it is probably best for you to wait until you return to the service area to get the care. If you wait, your Case Manager can help you get the service, and can actively participate in coordinating your care.

For more information, see the ***"Accessing Services in Special Situations"*** section of this Member Handbook.

Our Relationship With GHI

GuildNet Gold and Group Health Inc. (GHI), have formed a business relationship to provide you with a large network of providers that makes it possible for you to get the care you need, quickly, easily, and close to home. This network is called the GHI Choice PPO Provider Network. You can get the services that you used to receive using your Medicare card from the GHI Choice PPO Provider Network.

This Handbook gives you information about the services that you will get through the GHI Choice PPO Provider Network, but you should also look at your Evidence of Coverage for more information about getting these services

HOW TO JOIN GUILDNET GOLD

It is simple to join GuildNet Gold. The only paperwork that you need to complete is a GuildNet Gold enrollment form.

When you enroll in GuildNet Gold, you enroll in a Part D prescription drug program, a Medicare Advantage plan, and a Medicaid managed long-term care plan. Medicaid calls this managed long-term care plan Medicaid Advantage Plus. To you, the member, the combination of these two plans provides you with an integrated managed long-term care program. This program is GuildNet Gold. Through GuildNet Gold, you can get a full complement of medical services, long-term care services, environmental and social supports, and prescription drugs.

Eligibility

To become a member of GuildNet Gold, you must:

- Have full Medicaid
- Have evidence of Medicare Part A & B coverage; or be enrolled in Medicare Part C coverage; and
- Reside in Brooklyn, Queens, Manhattan or the Bronx; and
- Be 18 years of age or older; and
- Enroll in GuildNet Gold's Medicare Advantage and Medicaid Advantage Plus program; and
- Be eligible for nursing home level of care (as of the time of enrollment);
- Be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety; and
- Require care management and be expected to need at least one of the following services for at least 120 days from the effective date of enrollment;
    - nursing services in the home;
    - therapies in the home;
    - home health aide services;
    - personal care services in the home;
    - adult day health care; or
    - social day care if used as a substitute for in-home personal care services.

Not Eligible to Enroll in GuildNet Gold

You are not eligible to join GuildNet Gold if:

- You do not live in Brooklyn, the Bronx, Manhattan, or Queens.
- You are not eligible for Medicare Parts A and B AND Medicaid.

- You are medically determined to have End Stage Renal Disease (ESRD) at the time of enrollment.
- You are a resident of a residential health care facility ("RHCF") at the time of enrollment, and discharge back to the community is not expected within the first month following effective date of enrollment.
- You are enrolled in the NYS Medicaid Restricted Recipient Program.
- The New York City Human Resources Administration has determined that it is not cost effective for you to enroll because you have other insurance.
- You were admitted to a Hospice program prior to time of enrollment (If you enter a Hospice program while enrolled in GuildNet Gold you may remain enrolled).
- You are, and will continue to remain:
  - A resident of State-certified or voluntary treatment facility for children and youth.
  - A resident of a facility operated under the auspices of the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the Office of Mental Retardation and Developmental Disabilities (OMRDD).
  - Enrolled in another Medicaid managed care plan
  - Enrolled in a home and community-based services waiver program.
  - Enrolled in an OMRDD Day Treatment Program.

For more information about the eligibility requirements for GuildNet Gold, please call:

Member Services
1-800-932-4703
TTY number 800-662-1220
Monday through Friday
8:00 am to 8:00 pm

Enrolling In GuildNet Gold

Enrolling in GuildNet involves you, your family, your doctor, the NYC Human Resources Administration (HRA), Center for Medicare and Medicaid (CMS), and GuildNet Gold.

You, or your family, caregiver, or other referral source, may contact GuildNet Gold to notify us of your interest in joining GuildNet Gold. **To contact GuildNet Gold, call:**

1-800-932-4703
TTY Number 1-800-662-1220

A GuildNet Gold Intake staff member will follow up on every referral, and you will be contacted by telephone by our Intake staff who will provide you with basic information about our plan.

Member Service Number 1-800-932-4703
TTY Number 1-800-662-1220

Our Intake staff will ask you some questions to see if you are eligible to apply for coverage. They will ask you if you live in the service area, and if you have Medicaid. If you appear to meet basic eligibility for the plan, a Nurse Manager will arrange a meeting with you to conduct a comprehensive social and health assessment, and will evaluate your medical care needs.

If you meet the clinical requirements and all other eligibility requirements for enrollment into GuildNet Gold, the Nurse Manager will ask you if you would like to join the plan. If you do, you will be asked to sign an enrollment agreement. If you sign the enrollment agreement, you are agreeing to join a Medicare Advantage program and a Medicaid Advantage Plus program, which together, make up the integrated managed long-term care plan, GuildNet Gold.

Once you have agreed to join GuildNet Gold, the Nurse Manager will contact your doctor to notify him or her of your interest in joining GuildNet Gold, and to explain the services provided through GuildNet Gold. Your doctor must be willing to work with us in planning and managing your care. If your doctor is unwilling to work with us, and you still wish to enroll, we will assist you in choosing another doctor. If you do not have a doctor, we will assist you with getting one.

GuildNet Gold will process your enrollment application by sending it to both HRA and CMS. Once your enrollment has been approved by both HRA and CMS, we will notify you of the effective date of your enrollment, which is known as your "effective date of coverage." Your enrollment into GuildNet Gold will not be effective, until your enrollment into both Medicare Advantage and Medicaid Advantage Plus becomes effective.

Your enrollment into GuildNet Gold will usually be effective the 1st day of the month following the month in which you completed your application.

Once you are enrolled in GuildNet Gold, you will receive a GuildNet Gold identification card. You should use this card to get services covered by GuildNet Gold. For more information about your GuildNet Gold identification card, please see your GuildNet Gold Medicare Advantage Evidence of Coverage.

You need to keep your regular Medicaid card to get services that are not covered by GuildNet Gold, but that are still covered by regular Medicaid, such as pharmaceuticals not covered by GuildNet Gold.

If you change your mind about enrolling in GuildNet Gold, you can stop the process at any time. Enrolling in GuildNet Gold is completely up to you. Please contact Member Services if you wish to stop the enrollment process.

Disenrollment from GuildNet GOLD

Voluntary Disenrollment

You can ask to leave GuildNet Gold **at any time, for any reason**.

To request disenrollment, call Member Services at 1-800-932-4703 for help or call TTY Number 800-662-1220. Member Services will help you with the process. It could take up to six weeks for your disenrollment to be effective, depending on when your request is received by GuildNet Gold.

Involuntary Disenrollment

GuildNet Gold **must** disenroll you from its plan if:

- you are no longer a member of GuildNet Gold's Medicare Advantage program or are no longer a member of GuildNet Gold's Medicaid Advantage Plus Program;
- you lose Medicaid eligibility;
- you no longer reside in the GuildNet Gold service area and refuse to voluntarily disenroll;
- you are absent from the GuildNet Gold service area for more than ninety (90) consecutive days;
- you enter an OMH, OMRDD or OASAS residential program for forty-five (45) days or longer;
- you join a home and community based waiver program;
- you clinically require nursing home care but are not eligible for such care under the Medicaid institutional eligibility rules. In this event, GuildNet Gold will ensure your safe discharge to an appropriate program;
- you lose Medicare Parts A and B; or
- you join another Medicare Advantage Product, Medicaid Managed Care Plan, or Part D product.
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GuildNet Gold **may** disenroll you from its plan if:

- You, your family member, or informal caregiver, engages in conduct or behavior that seriously impairs GuildNet Gold's ability to provide you or another member, with service. Before we disenroll you, we must have made and documented reasonable efforts to resolve the conduct or behavior.
- You provide fraudulent information on an enrollment form or permit abuse of an identification card in the GuildNet Gold Program.
- You fail to pay or make arrangements satisfactory to GuildNet Gold to pay the amount that the NYC HRA determined that you owe GuildNet Gold as spenddown/surplus or Net Available Monthly Income (NAMI), within thirty (30) days from when the amount first becomes due, provided that during the thirty (30) day period we made a reasonable effort to collect the amount, including making a written request for payment, and advising you in writing of your prospective disenrollment.

- You knowingly fail to complete and submit any necessary consent or release.

YOUR COVERAGE WHEN YOU ARE NO LONGER A GUILDNET GOLD MEMBER

GuildNet Gold is a plan that is made up of two programs. One is Medicare Advantage, and the other is Medicaid Advantage Plus. If you disenroll from, or lose eligibility for our Medicare Advantage program, or if you disenroll from, or lose eligibility for our Medicaid Advantage Plus program, you will be disenrolled from GuildNet Gold. When your disenrollment is effective, your coverage:

- Will go back to regular Medicare and Medicaid fee-for-service; if you remain eligible for Medicaid and Medicare, or
- If you have joined another Medicaid or Medicare managed care plan, your coverage will be through the plan or program that you have joined.

OUT OF POCKET EXPENSES

Premiums, Deductibles, and Co-payments

When you join GuildNet Gold:

- You **DO NOT PAY THE MEDICARE PREMIUM IF** you currently do not pay the Medicare Part B premium.
- You **DO NOT HAVE TO PAY ANY DEDUCTIBLES**.
- There are **NO CO-PAYMENTS for any services,** other than prescription drugs.
- There **ARE CO-PAYS** for prescription drugs. For more information on which drugs have co-pays, please see your GuildNet Gold Medicare Evidence of Coverage.

HOW TO GET SERVICES

Your Case Manager

When you join GuildNet Gold, you will be assigned a Case Manager who is a health care professional who is usually either a nurse or a social worker. Your Case Manager is the person who you should call, to help you get the care that you need.

When you join GuildNet Gold, and on a regular basis after that, your Case Manager will talk to you, your family, caregivers, and doctors, and set up a plan of care for you that addresses your health care, social, and environmental needs. When your plan of care is agreed to by you, your family, caregivers, and doctors, your Case Manager will help you put the services you need in place. Your Case Manager will help you to get prior authorization for services, when prior authorization is needed. He or she can give you help in choosing providers, getting transportation to and from appointments, and even getting home delivered meals.

If you, a family member, or a caregiver, thinks that you need a service that is not in your plan of care, or that you need more service, or if you wish to discontinue a service, one of you should speak to your Case Manager to see if he or she can help you to get the service.

To contact your Case Manager call Member Services at:
Call 1-800-932-4703
TTY Number 1-800-662-1220

A copy of your plan of care is available to you upon request.

Getting Services That You Previously Received Using Your Medicare Card

GuildNet Gold offers services that you used to get from Medicare before your joined GuildNet Gold. When you got these services, you showed your provider your Medicare card. Now, you can get these services from our GHI Choice PPO Network, using your GuildNet Gold ID card.

You should try to use providers in the GHI Choice PPO Provider Network to get the care that you need. The providers in this network have been credentialed by us and we know that they provide quality care. You can go to a provider out-of-network, but you should remember that GuildNet Gold may not have experience with these providers, and we can not guarantee quality care from them.

Choosing a provider in the GHI Choice PPO Network can help you get the best possible care. This is because providers in the GHI Choice PPO Network have to work with our Case Managers, and participate in your plan of care. Out of network providers are under no obligation to do this. If you go to an out-of-network provider, it is possible that your Case Manager may not be able to manage the care you receive in the best possible way.

Member Service Number 1-800-932-4703
TTY Number 1-800-662-1220

GuildNet Gold recommends that you use a GHI Choice PPO Provider instead of going out of network. If you go to an out-of-network provider, please let your Case Manager know as soon as you can, so he/she can work with the provider on giving you the best care possible.

Some of the services that you used to get using your Medicare card require prior authorization. For these services, prior authorization is required whether or not the service is received through the GHI Choice PPO Provider Network or out of network. Please refer to the "*Covered Services"* section of this Member Handbook for more information.

If you need or want services:

Call Member Services and Ask to Speak to Your Case Manager

1-800-932-4703
TTY Number 1-800-662-1220

Getting Services That You Used To Get Using Your Medicaid Card

GuildNet Gold offers many services that you used to get from Medicaid, before you joined GuildNet Gold. When you got these services, you showed your provider your Medicaid card. Now, you will get these services from our GuildNet Gold Provider Network, using your GuildNet Gold ID card. However, please remember, you will need your Medicaid card to get Medicaid services not covered by GuildNet Gold.

You are free to choose any provider within the GuildNet Gold network, although you may need prior authorization to get service**.**

There may be times when GuildNet Gold will approve you to use a provider outside of the GuildNet Gold network. This can happen when GuildNet Gold does not have a provider with the training and expertise to meet a specialized health care need included in your plan of care. It can also happen when:

- You are under the care of a health care provider when you enroll in GuildNet Gold. You may continue treatment even if the provider is not in our network. (For example, if you are receiving dental care and the treatment is not finished.) You may continue treatment for up to sixty (60) days from when you join the plan. Your provider must agree to accept payment at the plan rate, follow our policies, and agree to provide us with medical information about your care.

- A GuildNet Gold network provider that you are in an ongoing course of treatment with, decides that they will no longer participate in the GuildNet Gold provider network. We will allow you to continue to see the provider for ninety (90) days until the transition to a new provider is in place. During that time, we will help

you to choose another provider from the GuildNet Gold provider network, and we will transition your care to the new provider.

Your provider must agree to accept payment at the plan rate, follow our policies, and agree to provide us with medical information about your care.

You should call your Case Manager if you have questions about going to an out-of-network provider.

If you need or want **a covered service that you used to get using your Medicaid card:**

Call Member Services and Ask to Speak to Your Case Manager

1-800-932-4703
TTY Number 1-800-662-1220

COVERED SERVICES

The chart below describes the services covered by GuildNet Gold.

The easiest way for you to get one of these services is for you to call your Case Manager. Your Case Manager can help with selecting a provider, making appointments, and getting prior authorization, when prior authorization is needed. Of course, you can always make an appointment directly with a provider, and have your provider assist you with gaining prior authorization if it is needed. To reach your Case Manager please call:

1-800-932-4703
TTY Number 1-800-662-1220

Service and Description
Adult Day Health Care Center • You are covered for Adult Day Health Care Center services. The services that you can receive at an Adult Day Health Center include: medical, nursing, food and nutrition, social services, dental, and pharmacy. • You do not have a co-payment or any out-of-pocket expense. • Prior authorization is required. **Contact your Case Manager.** • This is a service that you used to get using your Medicaid card. You will get this service now through the GuildNet Gold Provider Network. • For purposes of appeals and grievances, this is a Medicaid only covered service.
Ambulance • You are covered for ambulance services to an institution such as a hospital and a SNF and services dispatched from 911, where other forms of transportation would endanger your health. • You do not have a co-payment or any out-of-pocket expense. • You do not require prior authorization, except for planned ambulance transport. • This is a service that you used to get using your Medicare card. You may get this service now through the GHI PPO Choice Provider Network. • For the purpose of appeals and grievances, this is a service covered by Medicare and Medicaid.
Bone Mass Measurement • You are covered for Bone Mass Measurement procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results, if you are at risk of losing bone mass or at risk of osteoporosis. • The following services are covered every two (2) years or more frequently, if medically necessary: procedures to identify bone mass, detect bone loss, or

determine bone quality, including a physician's interpretation of the results.

- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Cardiac Rehab (Outpatient)

- Outpatient Cardiac rehabilitation therapy covered for patients who have had a heart attack within the last twelve (12) months, have had coronary bypass surgery, and/or have stable angina pectoris.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Certified Home Health Care

- You are covered for medically necessary skilled nursing care, home health aide services, social work, and rehabilitation services.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may get this service now through the GHI PPO Choice Provider Network or through the GuildNet Gold provider network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Chiropractic Services

- You are covered for Medicare Chiropractic services, which is manual manipulation of the spine to correct subluxation.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required after the first eight (8) visits. **Contact your Case Manager.**
- This is a service that you used to get using your Medicare card. You may get this service now through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicare.

Colorectal screening

- You are entitled to all medically necessary services, as well as the following:
- If you are 50 years old and older, you are covered for the following:

- Fecal occult blood test, every twelve (12) months.
- Flexible sigmoidoscopy (or screening barium enema as an alternative) every forty-eight (48) months.

- If you are at high risk of colorectal cancer, you are covered for:
  - Screening colonoscopy (or screening barium enema as an alternative) every twenty-four (24) months.
- If you are not at high risk of colorectal cancer, you are covered for:
  - Screening colonoscopy every ten (10) years, but not within forty-eight (48) months of a screening sigmoidoscopy.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now receive this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Dental

- You are covered for dental services including preventive, prophylactic, and other routine dental care, services and supplies, and dental prosthetics to alleviate a serious health condition.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required, in some cases. **Contact your Case Manager.**
- Some of these services are services that you used to get through Medicare and/or Medicaid. The GuildNet Gold Network will now provide you with this service through HealthPlex.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid only.

Diabetes Self-Monitoring

- You are covered for Diabetes self-monitoring, self-management training and supplies including coverage for glucose monitors, test strips, and lancets.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may get this service now through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Diagnostic testing (Outpatient)

- You are covered for diagnostic tests that include, but are not limited to, the following:
  - Laboratory tests.
  - Radiation therapy.
  - Surgical supplies, such as dressings.
  - Supplies, such as splints and casts.

- X-rays.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CT scan), Positron Emission Tomography (PET scan) and Nuclear Medicine Imaging is required. **Contact Your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Doctor Office Visits

- You are covered for office visits, including medical and surgical care, in a doctor's office or ambulatory surgical center. This includes visits to Primary Care doctors.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Durable Medical Equipment And Related Supplies

- You are covered for durable medical equipment, including devices and equipment such as wheelchairs, crutches, hospital beds, IV infusion pumps, oxygen equipment, nebulizers, and walkers, when medically necessary.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required for certain items. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Emergency Room

- You are covered for care provided in an emergency room anywhere in the world.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Hearing Services

- You are covered for diagnostic hearing exams.
- You are covered for medically necessary hearing services and products to alleviate

the loss or impairment of hearing. This includes hearing aid selecting, fitting, and dispensing, conformity evaluations and hearing aid prescriptions, and hearing aid products including hearing aids, hearing aid batteries, ear molds, special fittings, and replacement parts.

- You do not have a co-payment or any out-of-pocket expense.
- Authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid You may now get this service through the GHI Choice PPO Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Home Delivered and Congregate Meals

- You are covered for meals delivered to you at your home, or meals you get in a congregate setting, such as a senior center, if you are unable to prepare or have meals prepared for you.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- You will get this service through the GuildNet Gold Network.
- For purposes of appeals and grievances, this is a service covered by Medicaid only.

Immunizations

- You are covered for Hepatitis B vaccine if you are a person at risk.
- You are covered for the Flu shot, once a year.
- You are covered for the Pneumonia vaccine.
- You are covered for other vaccines if you are at risk.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Inpatient Hospital Care

- You are covered for unlimited days each benefit period.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required for non-emergency admissions. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You will now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Inpatient Mental Health Care

- You are covered for unlimited days each benefit period.
- You are covered for Partial Hospitalization which is a structured program of active treatment that is more intense than the care received in a doctor or therapist's office and is an alternative to inpatient hospitalization.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization may be required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Mammograms

- You will be covered for all medically necessary mammograms, including an annual screening if you are 40 years of age or older.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Medical and Surgical Supplies, Enteral/Parenteral Formulas and Supplements

- You are covered for medically necessary supplies, nutritional formula and supplements.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicaid.
- You will now get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Medical Social Services

- You are covered for the assessment, arrangement, and provision of aid for social problems that are the result of you living in your home.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that is covered by Medicaid. You may get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Nutrition

- You are covered for assessment of your nutritional status and needs, nutrition

education, and nutritional counseling. Your cultural dietary needs will be considered in the provision of these services.

- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service covered by Medicaid. You may get this through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Outpatient Drugs (Medicare Part B)

- You are covered for Medicare Part B covered prescription drugs and other drugs obtained by a provider and administered in a physician's office or clinic setting covered by Medicare.
- Prior authorization is not required.
- This is a service that you previously got using your Medicare and/or Medicaid cards. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicare and Medicaid.

Outpatient Mental Health Care

- You are covered for Mental Health services, individual and group therapy, provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, physician assistant, or other mental health professional as allowed under applicable State laws.
- You are covered for one (1) self-referral for an assessment, in a twelve (12) month period.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Outpatient Rehab

- You are covered for Occupational, Speech/Language, and Physical Therapy delivered on an outpatient basis.
- You do not have a co-payment or any out-of-pocket expense
- Prior authorization is required after twenty (20) visits for Physical Therapy, Speech Therapy and Occupational Therapy. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Outpatient Substance Abuse

- You are covered for individual and group visits to outpatient centers for substance

abuse.
- You are covered for one (1) self referral for an assessment, in a twelve (12) month period.
- You do not have a co-payment or any out-of-pocket expense
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Outpatient Surgery

- You are covered for medically necessary visits to an ambulatory surgery center, or outpatient hospital facility.
- You are also covered for ambulatory dental services.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization may be required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Pap Smears and Pelvic Exams

- Women are covered for Pap Smears and pelvic exams.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Personal Emergency Response System (PERS)

- You are covered for a PERS which is an electronic device that you can use to get help if you have a physical, emotional, or environmental emergency.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to receive using your Medicaid card. You will get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Personal Care Services

- You are covered for **medically necessary** assistance with activities of daily living, such as personal hygiene, dressing, and feeding.
- You do not have a co-payment or any out-of-pocket expense.

- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to receive using your Medicaid card. You will get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Podiatry Services

- You are covered for medically necessary foot care visits.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required in some instances. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Private Duty Nursing

- You are covered for medically necessary private duty nursing services when it is ordered by a physician, physician assistant, or nurse practitioner.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to receive using your Medicaid card. You will now get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Prostate Cancer Screening

- Medically necessary screening, including men aged 50 years and older. You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Prosthetics

- You are covered for prosthetics that replace a body part or function. These include 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 of prosthetic devices. It includes some coverage following cataract removal or cataract surgery.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required for certain items. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.

- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Routine Physical exams

- You are covered for one (1) routine physical exam each year.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to receive through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Skilled Nursing Facility

- You are covered for unlimited days each benefit period for services received in a Medicare certified skilled nursing facility, for short-term rehabilitation, or long-term placement.
- You do not have a co-payment or any out-of-pocket expense
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to get through Medicare and/or Medicaid**.** You may get this service through the GHI PPO Choice Provider Network or the GuildNet Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Social Day Care

- You are covered for Social Day Care, which is a program that provides you with the opportunity to go to a location on a regularly scheduled basis, where you can socialize, receive meals, personal care, and monitoring, all under the supervision of trained staff.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service covered by Medicaid. You will get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a service covered by Medicaid only.

Social and Environmental Supports

- You are covered for services and items that support your medical needs. These services can include: home maintenance tasks, homemaker/chore services, housing, improvement, and respite care.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service covered by Medicaid. You will get this service through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a Medicaid-only covered service.

Specialist Office Visits

- You are covered for specialist office visits that include:
  - Medical and surgical care in a physician's office or certified ambulatory surgical center.
  - Consultation, diagnosis, and treatment by a specialist.
  - Second opinion prior to surgery.
  - Outpatient hospital services.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may now get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Transportation (non-emergency)

- You are covered for non-emergency transportation when you need to obtain medical care and services. This includes ambulette, planned ambulance, invalid coach, taxicab, livery, public transportation, or other means that are appropriate to your medical condition and, if you need, a transportation attendant to accompany you. The mode of transportation will be based on your medical condition.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is required. **Contact your Case Manager.**
- This is a service that you used to receive using your Medicaid card. You will now get this through the GuildNet Gold Provider Network.
- For purposes of appeals and grievances, this is a service covered by Medicaid only.

Urgent Care

- You are covered for urgently needed care anywhere in the world.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization is not required.
- This is a service that you used to get through Medicare and/or Medicaid. You may get this service through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Vision Care Services

- If you are at high risk of glaucoma, (you have a family history of glaucoma, you have diabetes, or are African-American aged 50 and older) you are covered for glaucoma screening once per year.
- You are covered for artificial eyes, low vision aids, and low vision services.
- You are covered for medically necessary contact lenses~~,~~ and polycarbonate lenses.

- You are covered for one pair of eyeglasses or contact lenses, after each cataract surgery that you have that includes insertion of an intraocular lens. You are also covered for corrective lenses/frames (and replacements) that you need after a cataract removal without a lens implant.
- You are covered for one new pair of eyeglasses every year from the Davis Vision eyewear collection, in addition to replacement of lost or destroyed glasses. Replacement of lost, damaged, or destroyed eyeglasses/contact lenses are covered under certain conditions.
- You are covered for routine vision exams every year.
- You are covered for outpatient physician services for eye care.
- You do not have a co-payment or any out-of-pocket expense.
- Prior authorization may be required. **Contact your Case Manager.**
- Some of these services you used to get through Medicare and/or Medicaid. You may access these services through the GHI PPO Choice Provider Network.
- For the purpose of appeals and grievances, this is a service that is covered by Medicaid and Medicare.

Health and Wellness Education Program

- General Education.
- Parenting.
- Smoking Cessation classes.
- Childbirth education.
- Nutritional counseling.
- Health Advocate Counseling.
- **Contact your Case Manager for More Information.**

PART D PRESCRIPTION DRUG COVERAGE: See your Evidence of Coverage

PAYING PROVIDERS FOR COVERED SERVICES

Payment to all of our providers for approved covered services will be made by GuildNet Gold. Providers are paid on a “fee-for-service” basis. This means that our providers get a GuildNet Gold agreed-upon fee for each service he/she provides. This is true for providers in the GHI PPO Choice Provider Network and the GuildNet Gold Provider Network.

SERVICES COVERED BY REGULAR MEDICARE OR MEDICAID FEE-FOR- SERVICE, NOT BY GUILDNET GOLD

There are some Medicare and Medicaid services that GuildNet Gold does not cover. You can get these services from a provider using your Medicare or Medicaid Benefit Card.

- **Hospice:** This is a coordinated program of home and inpatient care provided to people who have been certified by a doctor as terminally ill, and expected to live six (6) months or less. While this service is not covered by GuildNet Gold, you can receive Hospice services from regular Medicare.

- **Certain Drugs, Pharmacy Items, and Vitamins:**

    - Medicaid fee-for-service covers barbiturates, benzodiazepines, some prescription vitamins, and some non-prescription drugs and items. These are drugs, pharmacy items, and vitamins that are not covered by GuildNet Gold's Part D coverage.
    - Under certain conditions, Medicaid fee-for-service pays for atypical antipsychotics, antidepressants, anti-retrovirals used in the treatment of HIV/AIDS, and anti-rejection drugs used in the treatment of tissue and organ transplants. These drugs, which are normally covered by GuildNet Gold's Part D benefit, are paid for by Medicaid fee-for-service when you do not meet GuildNet Gold's utilization management requirements for these drugs, or there are quantity limits on these drugs that exceed the amount that your doctor prescribed for you.

- **Out of Network Family Planning Services**

  You can go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP). The provider will be reimbursed directly by Medicaid fee-for-service.

- **Methadone Maintenance Treatment Program (MMTP)**

  MMTP consists of drug detoxification, drug dependence counseling and rehabilitation services which include chemical management of the patient with methadone. You can get these services from Medicaid fee-for-service.

- **Certain Mental Health Services**

  You can get the following mental health services from Medicaid fee-for-service:

    - Intensive psychiatric rehabilitation treatment
    - Day treatment

- Rehabilitation services to those in community homes or in family-based treatment
- Continuing day treatment
- Assertive community treatment
- Personalized recovery oriented services

- **Mental Retardation and Developmental Disabilities Services**

  You can get the following services from Medicaid fee-for-service:
  - Long-term therapies
  - Medicaid Service Coordination

- **Comprehensive Case Management Programs**

  These are programs that provide "social work" case-management referral services to a targeted population. These services will be covered by Medicaid fee-for-service.

- **Directly Observed Therapy for Tuberculosis Disease**

  You can receive directly observed therapy, which is the direct oral ingestion of TB medication to assure patient compliance with the physician's prescribed medication regimen. This service is covered under fee-for-service.

- **AIDS Adult Day Health Care**

  You can get Adult Day Health Care Programs that assist people with HIV disease to live more independently in the community or eliminate the need for residential health care services under fee-for-service.

SERVICES NOT COVERED BY GUILDNET GOLD OR REGULAR MEDICARE OR MEDICAID FEE-FOR-SERVICE

You must pay for services that are not covered by GuildNet Gold or by Medicaid if your provider tells you in advance that these services are not covered, **AND YOU AGREE, IN WRITING, TO PAY FOR THEM.** Examples of services not covered by GuildNet Gold or Medicaid include, but are not limited to:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Dental Implants

ACCESSING SERVICES IN SPECIAL SITUATIONS

What is an Emergency?

An emergency is a medical condition that has acute symptoms of sufficient severity, for

example, severe pain, such that a prudent lay-person 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 pregnant woman, to the health of the woman or the unborn child; serious impairment to bodily functions; or serious dysfunction of any body organ or part.

What to do in an Emergency

Call 911

You **do not have to get prior authorization from GuildNet Gold in order** to get emergency medical help.

If you have an emergency medical condition, go to the nearest emergency room, or **call 911** for assistance.

Getting Care Outside of the Service Area

You may receive **emergency care anywhere in the world**.

You may receive all **other out of area care anywhere in the United States**. Prior authorization rules described in this member handbook must be followed, when they apply.

Wherever you are, it is important that either you, a family member or a friend call your GuildNet Case Manager as soon as possible. Your membership card lists the toll-free number that you can call. Your Case Manager can rearrange any scheduled services that you might miss at this time, and begin to make any necessary changes to your plan of care. He/she will help you to avoid any unnecessary gaps in the services that you need.

If the service that you want when you are out of area is not vital to your health and well being, it might be best for you to wait until you return home to get the service. This will allow your Case Manager to be more actively involved in your care. If it is a long-term care service that you are seeking, remember that you will be disenrolled from GuildNet Gold if you do not return to the service area within ninety (90) days.

How to Get Help after Business Hours

It is always best for you to discuss your questions directly with your Case Manager, who knows you best, during business hours.

However, you might have an **urgent need** for help, or questions that cannot wait until business hours. If you need help after hours, on a weekend, or on a holiday, contact us at our 24-hour toll-free number, and a GuildNet representative will help you.

1-800-932-4703
TTY Number 1-800-662-1220

SERVICE AUTHORIZATION AND ACTIONS

When you ask for approval of a treatment or service, it is called a **service authorization request**. To get a service authorization you **should call your Case Manager or Member Services at:**

1-800-932-4703
TTY Number 1-800-662-1220

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

Some of the services you receive from GuildNet Gold are covered only by Medicare, some only by Medicaid and some are covered by both Medicare and Medicare, (See the *Covered Services* section of this Member Handbook for more information.) The way GuildNet Gold makes decisions about services depends on whether the service is covered by Medicaid and/or Medicare.

When GuildNet Gold determines that services are covered by **Medicaid** we will make decisions about your care following the rules described below. For the rules about GuildNet Gold service authorization process for services covered by Medicare, please refer to your Evidence of Coverage.

Medicaid Service Authorization Rules

Prior Authorization

Some of the GuildNet Gold covered services described in this Member Handbook, in particular the services that you used to get using your Medicaid card, need **prior authorization** (approval in advance), from your Case Manager, before you receive them, or in order to be able to continue receiving them. (See the *Covered Services Section* of this Member Handbook for information about which services require prior authorization.)

Concurrent Authorization

You will also need to get prior authorization if you are receiving a service now that is only covered by Medicaid, but need to get more of the care during an authorization period. This is called **concurrent authorization**.

What happens after we get your service authorization request?

When GuildNet Gold gets your service authorization request, we evaluate your request against established clinical review criteria.

Any decision to deny a service authorization request, to approve it for an amount or time period that is less than requested, or reduce, suspend, or terminate a service, that we have already

approved, is called an **ACTION**. These decisions will be made by a qualified health care professional. If we decide that the service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific criteria, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **expedited** (fast track) process. You or your doctor can ask for an expedited review if it is believed that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you in writing and let you know your request will be handled under the standard review time frames. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than the time frame identified below.

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

Time Frames for Prior Authorization Requests

- Standard review: We will make a decision about your request within three (3) business days of receiving all the information we need, but you will hear from us no later than fourteen (14) days after we receive your request. We will tell you by the 14th day if we need more information.

- Expedited review: We will make a decision and you will hear from us within three (3) business days. We will tell you by the third business day if we need more information.

Time Frames for Concurrent Authorization Requests

- Standard review: We will make a decision within one (1) business day after we have received all of the information we need, but you will hear from us no later than fourteeen (14) days after we have received your request.

- Expedited review: We will make a decision within one (1) business day after we have received all of the information we need, but you will hear from us no later than three (3) business days after we have received your request.

If we need more information to make either a standard or expedited decision about your service request, the time frames above can be extended up to fourteen (14) days. We will:

- Write and tell you what information is needed. If your request is for an expedited 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 have received the necessary information, but no later than fourteen (14) days from the original request.

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 us that will help us to decide your case. This can be done by calling **Member Services at 1-800-932-4703, TTY Number 1-800-662-1220** or by writing to us at the address on the letter that we sent you.

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

We will notify you of any decision we make about your request for services in writing. If you are not satisfied with our decision about a Medicaid service, you have the right to file a Medicaid Action Appeal (See the Action Appeal Section of this Member Handbook for further information.)

OTHER DECISIONS ABOUT YOUR MEDICAID SERVICES

Sometimes we will do a review on the care you are receiving to see if you still need the care. If we find that you do not need the services you are currently receiving, this can result in a termination, suspension or reduction of benefits. In most cases, we will tell you in writing, at least ten (10) days before we change your services. You may also file a Medicaid Action Appeal if you disagree with our decision.

Reconsiderations

If we made a decision about your service authorization request without talking to your health care provider, your health care provider may ask to speak with the plan's Medical Director. The Medical Director will talk to your health care provider within one (1) business day.

ACTION APPEALS

As a Dually-Eligible (Medicare and Medicaid) member of our plan, the way in which you make appeals our decisions about your services will depend on whether the services are covered by Medicare and/or Medicaid (See the "*Covered Services"* section of this Member Handbook for more information.)

- **Medicare Services:** For appeals about a service that is covered only by Medicare (Chiropractic services and Part D Prescription Drug Benefits), you will follow the rules outlined in your Evidence of Coverage. You will also follow these rules if you think that you are being discharged from the hospital too soon, or if you think your coverage for

Skilled Nursing Facility, Certified Home Health Care, or Comprehensive Outpatient Rehabilitation is ending too soon, and we told you the decision we made was based on Medicare rules.

- **Medicaid Services:** For appeals about a service that is covered only by Medicaid, examples of which are: personal care services, private duty nursing, non-emergency transportation, dental services, see the *Covered Benefits Section* of this Member Handbook for more information, You will follow the Medicaid rules listed below.

- **Medicaid and Medicare Services**: For appeals about all other services covered by GuildNet Gold (for services covered by Medicare and Medicaid see the *Covered Services* section of this Member Handbook), you may choose to follow either the Medicare rules outlined in your Evidence of Coverage, or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid appeal rights, including the right to a NYS Medicaid Fair Hearing. But if you choose to follow the Medicaid rules, you will have up to sixty (60) days from the day of GuildNet Gold's notice of denial of coverage to use your Medicare appeal rights.

- **If you don't make a choice between the Medicare and Medicaid rules, we will follow the Medicaid rules.**

We understand that the Appeals process may be confusing to you. GuildNet Gold will explain the appeals processes available to you depending on your issue. **Call Member Services at 1-800-932-4703, TTY Number 800-662-1220 to get more information on your rights and the options available to you.**

How to File a Medicaid Appeal

- If you are not satisfied with the action we have taken concerning the services that you are currently receiving or with our decision about your service authorization request, you have forty-five (45) business days, after receiving our written decision, to file an appeal.

  You can do this yourself or ask someone you trust to file the appeal for you.

  If you need help filing an appeal you can call:

  Member Services
  1-800-932-4703
  TTY Number 1-800-662-1220

- We will not treat you any differently or act badly toward you because you file an appeal.

- The appeal can be made by phone or in writing.

Your Medicaid action appeal will be reviewed under the expedited (fast track) process if:

- You or your health care provider ask to have your appeal reviewed under the expedited process. Your health care provider will have to explain how a delay in making our decision will cause harm to your health. If your request for review under the expedited process is denied, we will tell you in writing, and let you know that your appeal will be reviewed under the standard process;

- Your request was denied when you asked to continue receiving care that you are now getting, or need to extend a service that has been provided.

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

What happens after we get your Medicaid Appeal

- Within fifteen (15) days, we will send you a letter to let you know we are working on your appeal. We will let you know if we need additional information to make our decision.

- Action Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom will be a clinical peer reviewer.

- Non-clinical decisions will be handled by a person other than the one that made your first decision.

- Before and during the appeal, you or your designee can see your case file, including medical records and any other documents and records being used to make a decision on your case.

- You can also provide information to be used in making the decision in person or in writing.

- We will give you the reasons for our decision and our clinical rationale, if it applies, in writing. We will also let you know about appeal rights that are available to you, if you are not satisfied with our decision.

- You or someone you trust can always file a complaint with the New York State Department of Health at 1-800-206-8125, TTY Number 1-800-662-1220. However, you should know that this is not the same as filing a request for a NYS Medicaid Fair Hearing. (See the Fair Hearings section for instructions on how to file a NYS Medicaid Fair Hearing request.)

Time Frames for Medicaid Action Appeals

- Standard appeals: If we have all the information we need, we will tell you our decision within thirty (30) days from the date of your appeal. A written notice of our decision will be sent within two (2) business days from the day we made the decision.

- Expedited appeals: If we have all the information we need, expedited appeal decisions will be made within two (2) business days from your appeal. We will tell you within three (3) business days after we receive your appeal if we need more information. We will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or expedited decision about your Medicaid action appeal we will

- Write to tell you that we need more time to collect the information. If your request is an expedited review, we will call you right away, and send a written notice later.

- Tell you why the delay is in your best interest.

- Take no more than fourteen (14) additional days to make a decision.

Asking for more time

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 which will help to decide your case. This can be done by calling **1-800-932-4703, TTY Number 1-800-662-1220** or by writing to the address on the letter that you received from us.

You or someone you trust can file a grievance with the plan if you don't agree with our decision to take more time to review your action appeal. You or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197, but that will not allow you to request a Medicaid Fair Hearing.

If your original denial was because we said the Medicaid service was not medically necessary or was experimental or investigational, and we do not tell you our decision about your appeal within the time frames above, the original denial against you will be reversed. This means your service authorization request will be approved.

Aid to Continue while appealing a decision about your Medicaid services

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

- Within ten (10) days from our notice to you that care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received as a result of requesting an appeal about those benefits.

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

New York State External Appeals

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

Before you appeal to New York State:

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

You have forty-five (45) days after you receive the plan's final decision to ask for a NYS External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the Medicaid External Appeal within forty-five (45) days of the date when you made that agreement.

You will lose your right to a NYS External Appeal if you do not file an application for a NYS External Appeal on time.

To ask for an External Appeal, you will need to fill out an application and send it to the State Insurance Department. You can call Member Services at 1-800-932-4703, TTY Number 800-662-1220 if you need help filing an appeal. You and your doctors will have to give information about your medical problem.

Here are some ways to get an application:

- Call the State Insurance Department, 1-800-400-8882
- Go to the State Insurance Department's website at www.ins.state.ny.us
- Contact the health plan at 1-800-932-4703

Your NYS External Appeal will be decided in thirty (30) days from the date the State Insurance Department receives your application. More time (up to five business days) may be needed if the external appeal reviewer asks for more information. You and the plan will be told the final decision within two (2) days after the decision is made.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **Expedited External Appeal**. The external appeal reviewer will decide an expedited appeal in three (3) days or less. The reviewer will tell you and the plan the decision right away by phone or by fax. Later, a letter will be sent that tells you the decision.

You may also ask for a Medicaid Fair Hearing if we deny your appeal. You may request both a NYS Medicaid Fair Hearing and a NYS External Appeal, as well. If you ask for a Fair Hearing and an External Appeal, the decision of the NYS Fair Hearing officer will be the one that counts.

FAIR HEARINGS FOR SERVICES COVERED BY MEDICAID

You may ask for a New York State Medicaid Fair Hearing if we deny your appeal. You may ask for both a NYS External Appeal and a NYS Medicaid Fair Hearing. However, if you ask for both, it will be the decision of the Fair Hearing officer that counts. If you filed an appeal under Medicare rules, you may not then request a Fair Hearing about the same appeal.

You may also request a Fair Hearing if you are not happy with a decision your local Department of Social Services made about your enrollment in, or disenrollment from, GuildNet Gold.

In some cases, you may be able to keep getting care in the same way while waiting for your Fair Hearing. This is called "aid to continue".

If we decide to change the Medicaid services that we previously authorized, you may be able to continue receiving services while you wait for your NYS Medicaid Fair Hearing decision. You may be able to continue the services that are scheduled to end or be reduced if you ask for a NYS Medicaid Fair Hearing:

- Within ten (10) days from the date you received our decision about your appeal and we told you in the appeal decision that we were still intending to change your care or service; or
- By the date the change in care or services is scheduled to occur.

If the Fair Hearing decision is not in your favor, you may have to pay the costs of any continued benefits you received solely as a result of requesting a Fair Hearing about those benefits.

To request a Fair Hearing, fill out the Fair Hearing Notice that we send you with our decision, if the decision is not in your favor. You can call **Member Services at 1-800-932-4703, TTY Number 1-800-662-1220,** if you need help filing your request for a Fair Hearing.

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

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

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

Remember, you can file a complaint at any time with the New York State Department of Health by calling 1-866-712-7197. **Call Member Services at 1-800-932-4703, TTY Number 1-800-662-1220** if you have any questions.

GRIEVANCES

We hope our plan serves you well. If there are unfortunate circumstances where you have a problem with the care or treatment you receive from our staff or providers, or you do not like the quality of care or services you receive from us, call Member Services:

1-800-932-4703
TTY Number 1-800-662-1220

Most problems can be solved right away if you call us promptly. Problems that are not solved the same day will be handled according to the process described below.

You can always ask someone you trust to file the grievance 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 grievance.

If you chose to make a grievance in writing, your grievances must be sent to the following addresses, as described below:

GuildNet Gold
Appeals Department
P.O. Box 4296
Kingston, NY 12402

Grievances About Prescription Drug Program Should Be Sent To:

P.O. Box 4296
Kingston, NY 12402

Or Call

1-866-557-7300.
TTY number 1-866-248-0640

Grievances about services that are only a benefit under Medicare (Chiropractic or Part D Prescription Drugs): will follow the GuildNet Gold Medicare grievance process. (Please see your Evidence of Coverage for instructions.)

Grievances about services covered only by Medicaid (those services such as personal care, private duty nursing, and other services that you used to get using your Medicaid card): will follow the GuildNet Gold Medicaid grievance process, described below.

Grievances about all other services (those covered by both Medicare and Medicaid): you can choose to use either the Medicare or Medicaid grievance process. If you need assistance choosing which grievance process to follow, our Member Services staff can answer any questions that you may have. If you don't make a choice between the Medicare and Medicaid rules, we will follow the Medicaid rules.

We understand that the grievance process may be confusing to you. GuildNet Gold will explain the grievance processes available to you depending on your issue. **Call Member Services at 1-800-932-4703, TTY Number 1-800-662-1220 to get more information on your rights and the options available to you.**

Medicaid Grievance Process

If we don't solve the problem to your satisfaction right away over the phone - or after we get your written grievance - we will send you a letter within fifteen (15) business days. The letter will tell you:

- who is working on your grievance;
- how to contact this person and
- if we need more information to resolve your grievance.

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

We will let you know our decision in forty-five (45) days of the date when we have all the information we need to answer your grievance, but you will hear from us in no more than sixty (60) days from the day we get your grievance. We will write to you and will tell you the reasons for our decision.

When a delay would be a risk to your health, we will expedite (fast track) our review and let you know our decision in 48 hours of the date when we have all the information we need to answer your grievance, but you will hear from us in no more than seven (7) days from the day we get your grievance. We will call you with our decision. You will get a letter within three (3) business days of when we make our decision.

If we do not have the information we need to make a decision about your Medicaid grievance we will

- Write to tell you that we need more time to collect the information. If your grievance is being expedited, we will call you right away to tell you what information we need, and send a written notice later.

- Tell you why the delay is in your best interest;

- Take no more than fourteen (14) additional days to make a decision.

You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need in order to appeal our decision.

Medicaid Grievance Appeals

If you disagree with a decision we made about your grievance, you or someone you trust can file a Medicaid **Grievance Appeal** with the plan.

- You have sixty (60) business days after receiving our written decision to file an appeal.
- You can file the appeal yourself or ask someone you trust to file the appeal for you.
- The appeal can be made in writing, or you can call Member Services. After your call, we will send you a form which is a summary of your phone appeal. If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

After we get your Grievance Appeal we will send you a letter within fifteen (15) business days. The letter will tell you:

- who is working on your Grievance Appeal
- how to contact this person
- if we need more information to make a decision about your appeal.

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

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

MEMBER RIGHTS AND RESPONSIBILITIES

Your rights as a GuildNet Gold Member, at a minimum, include the right to:

- Receive medically necessary care.
- Privacy about your medical record and when you get treatment.
- Timely access to care and services.
- Get information on available treatment options and alternatives presented in a manner and language you understand
- Get information in a language you understand; you can get oral translation services free of charge.
- Get information necessary to give informed consent before the start of treatment.
- Be treated with respect and dignity.
- Get a copy of your medical records and ask that the records be amended or corrected.
- Tell GuildNet about your care needs and concerns and work with your Case Manager in addressing them.
- Take part in decisions about your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- Be told where, when, and how, to get the services you need from GuildNet, including how you can get covered benefits from out-of-network providers.
- Complain to GuildNet, the New York State Department of Health or the New York City Human Resources Administration, and in some instances, the right to use the New York State Fair Hearing System, to request a NYS External Appeal, or appeal to the CMS designated agency.
- Appoint someone to speak for you about your care and treatment.
- Make advance directives and plans about your care.

Your responsibilities as a GuildNet Gold member, at a minimum, include your responsibility to:

- Get approval from your physician and your Case Manager before receiving a covered service that requires prior approval.
- Notify GuildNet Gold when you are out of the service area.
- Make all required payments to GuildNet Gold; and,

- Cooperate with any requests for documentation related to maintaining your Medicaid eligibility.

You may have additional rights and responsibilities through your Medicare coverage. Please see your Evidence of Coverage for more information.

Getting Information about GuildNet and GuildNet Gold

GuildNet Gold is one of the health care programs offered by GuildNet. You can get more information about GuildNet and GuildNet Gold whenever you wish. For more information you should call Member Services at:

1-800-932-4703
TTY Number 1-800-662-1220
Monday through Friday
8:00 am to 8:00 pm

The following information is available upon request:

- Names, addresses, and positions of the Officers and Board of Directors.
- Most recent GuildNet annual certified financial statement.
- Information on consumer grievances.
- Procedures for confidentiality of member information.
- Quality management program and procedures.
- Clinical review criteria that is used in utilization review. (This information must be requested in writing.)
- Application procedures and minimum qualification requirements for GuildNet Gold health care providers, including providers in the GHI Choice Network.