GuildNet
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Vision+Health

GuildNet Gold Plus FIDA Plan

MMP-POS

Participant Handbook 2015

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GuildNet Gold FIDA Plus Plan

Participant Handbook

January 1, 2015-December 31, 2015

Your Health and Drug Coverage under GuildNet Gold Plus FIDA Plan MMP-POS

This handbook tells you about your coverage under GuildNet Gold Plus FIDA Plan MMP-POS (Medicare-Medicaid Plan) from the date you are enrolled with our plan through December 31, 2015. It explains how our plan covers Medicare and Medicaid services, including prescription drug coverage, at no cost to you. It explains the health care services, behavioral health services, prescription drugs, and long-term services and supports that the Plan covers. Long-term services and supports include long-term facility-based care and long-term community-based services and supports. Long-term community-based services and supports provide the care you need at home and in your community, and can help reduce your chances of going to a nursing facility or hospital.

This is an important legal document. Please keep it in a safe place.

GuildNet Gold Plus FIDA Plan is a Fully Integrated Duals Advantage (FIDA) Plan that is offered by GuildNet, Inc. When this *Participant Handbook* says "we," "us," or "our," it means GuildNet, Inc. When it says "the plan" or "our plan," it means GuildNet Gold Plus FIDA Plan.

Disclaimers

GuildNet Gold Plus FIDA Plan is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

Limitations and restrictions may apply. For more information, call the Plan Participant Services or read the Plan Participant Handbook. This means that you need to follow certain rules to have our Plan pay for your services.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

GuildNet Gold Plus FIDA Plan is an MMP-POS plan with a Medicare and New York State Medicaid contract. Enrollment in GuildNet Gold Plus FIDA Plan depends on contract renewal.

You can get this information for free in other languages. Call 1-800-815-0000 and TTY/TDD 1-800-662-1220 during 8am to 8pm. The call is free.

Usted puede obtener esta información en otros idiomas gratis. Llame al 1-800-815-0000 o TTY/TDD al 1-800-662-1220, de lunes a domingo de 8am a 8pm. La llamada es gratis.

Queste informazioni sono disponibili gratuitamente in altre lingue. Chiamare il numero verde 1-800-815-0000 o 1-800-662-1220 mediante un telefono testuale per non udenti (TTY/TDD), da lunedì a domenica, dalle 8 alle 20. La chiamata è gratuita.

您可以免費獲得本信息的其他語言版本。請撥打 1-800-815-0000 或*聽障*／語障人士專線 (TTY/TDD) 1-800-662-1220，星期一至星期日上午 8 時至晚上 8 時。撥打該電話免費。

Ou kapab jwenn enfòmasyon sa yo gratis nan lòt lang. Rele nimewo 1-800-815-0000 oswa TTY/TDD 1-800-662-1220, lendi jiska dimanch, depi 8am jiska 8pm. Koutfil la gratis.

다른 언어로 작성된 이 정보를 무료로 얻으실 수 있습니다. 월요일 - 일요일 오전 8시부터 오후 8시 사이에 1-800-815-0000번이나 TTY/TDD 1-800-662-1220번으로 전화주세요. 통화는 무료입니다.

Вы можете бесплатно получить эту информацию на других языках. Позвоните по телефону 1-800-815-0000 и TTY/TDD 1-800-662-1220. Служба работает с понедельника по воскресенье с 08:00 до 20:00 ч. Звонок бесплатный.

You can ask for this handbook in other formats, such as Braille or large print. Call Participant Services at 1-800-815-0000 and TTY/TDD 1-800-662-1220 between 8am to 8pm.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by GuildNet Gold Plus FIDA Plan. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.

Chapter 1: Getting started as a Participant

Table of Contents

A. Welcome to GuildNet Gold Plus FIDA Plan

Our Plan is a Fully Integrated Duals Advantage (FIDA) Plan. A *FIDA Plan* is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has Care Managers and Interdisciplinary Teams (IDTs) to help you manage all your providers and services. They all work together to provide the care you need.

GuildNet Gold Plus FIDA Plan was approved by New York State and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the FIDA Demonstration.

FIDA is a demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the state and federal government want to test new ways to improve how you receive your Medicare and Medicaid health care services. At present, this demonstration is scheduled to last until December 31, 2017.

Our Plan is a Point of Service Plan. This means that for services you received under Medicare, you can see any Provider who accepts Medicare as long as the Provider agrees to participate in the FIDA demonstration.

B. What are Medicare and Medicaid?

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Medicaid

Medicaid is a program run by the federal government and New York State that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides what counts as income and resources and who qualifies. Each state also decides which services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

Medicare and New York State must approve the Plan each year. You can get Medicare and Medicaid services through our plan as long as:

- You are eligible to participate in the FIDA Demonstration,
- We choose to offer the FIDA Plan, and
- Medicare and New York State approve our Plan to participate in the FIDA Demonstration.

If at any time our plan stops operating, your eligibility for Medicare and Medicaid services will not be affected.

C. What are the advantages of this FIDA Plan?

In the FIDA Demonstration, you will get all your covered Medicare and Medicaid services from the Plan, including long-term services and supports (LTSS) and prescription drugs. You do not pay anything to join or receive services from this plan.

Our Plan will help make your Medicare and Medicaid benefits work better together and work better for you. Here are some of the advantages of having our Plan:

- You will have an Interdisciplinary Team that you help put together. An Interdisciplinary Team (IDT) is a group of people that will get to know your needs and work with you to develop and carry out a Person-Centered Service Plan specific to your needs. Your IDT may include a Care Manager, doctors, service providers, or other health professionals who are there to help you get the care you need.
- You will have a Care Manager. This is a person who works with you, with the Plan, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your IDT and your Care Manager.
- The IDT and Care Manager will work with you to come up with a Person-Centered Service Plan specifically designed to meet your needs. The IDT will be in charge of coordinating the services you need. This means, for example:
  - » Your IDT will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - » Your IDT will make sure your test results are shared with all your doctors and other providers.
  - » Your IDT will help you schedule and get to appointments with doctors and other providers.

D. What is GuildNet Gold Plus FIDA Plan's service area?

The Plan's service area includes Bronx, Brooklyn, New York, Queens, Richmond, and Nassau Counties.

Only people who live in our service area can join our Plan.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan Participant?

You are eligible for our plan as long as:

- you live in our service area;
- you are entitled to Medicare Part A, enrolled in Medicare Part B, and eligible for Medicare Part D;
- you are eligible for Medicaid;
- you are age 21 or older at the time of enrollment;
- you require 120 or more days of community-based or facility-based LTSS, are nursing facility clinically eligible and receive facility-based long-term support services, or are eligible for the Nursing Home Transition and Diversion (NHTD) 1915(c) waiver; and
- you are not excluded from enrollment based on one of the exclusions listed below.

You will be excluded from joining our plan if:

- you are a resident of a New York State Office of Mental Health (OMH) facility or a psychiatric facility;
- you are receiving services from the State Office for People with Developmental Disabilities (OPWDD) system – whether receiving services in an OPWDD facility or treatment center, receiving services through an OPWDD Waiver, whether you could be receiving services in an ICF/IID but you have chosen not to, or otherwise;
- you are expected to be Medicaid eligible for less than six months;
- you are eligible for Medicaid benefits only for tuberculosis related services, breast cancer services, or cervical cancer services;
- you are receiving hospice services (at time of enrollment);
- you are eligible for the family planning expansion program;
- you are a resident of an alcohol/substance abuse long-term residential treatment program;

- you are eligible for Emergency Medicaid;
- you are enrolled in the 1915(c) waiver program for Traumatic Brain Injury (TBI);
- you participate in and reside in an Assisted Living Program; or
- you are in the Foster Family Care Demonstration.

F. What to expect when you first join a FIDA Plan

When you first join the plan, you will receive a comprehensive assessment of your needs within the first 30 or 60 days depending on your enrollment type and date. The assessment will be conducted by a Registered Nurse from our Plan.

If our Plan is new for you, you can keep seeing the doctors you go to now and getting your current services for a certain amount of time. This is called the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later. Because GuildNet Gold Plus FIDA Plan is a **Point of Service** plan**,** you may continue using an out-of-network provider for Medicare-covered services after the transition period. However, it always is best for you to see an in-network provider.

After the transition period, you will need to see doctors and other providers in the Plan's network for services covered by your Medicaid benefit. *A network provider is a provider who works with us.* See Chapter 3 for more information on getting care.

There are three exceptions to the transition period described above:

- If you are a resident of a nursing facility, you can continue to live in that nursing facility for the duration of the FIDA Demonstration, even if the nursing facility does not participate in the Plan's network.
- If you are receiving services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in our Plan's network.
- You may continue to see out-of-network providers for services covered by Medicare. If you go to an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

G. What is a Person-Centered Service Plan?

After our Plan's Registered Nurse conducts the comprehensive assessment, you will meet with the members of your Interdisciplinary Team (IDT) to talk about your needs and develop your Person-Centered Service Plan (PCSP). A PCSP is the plan for what health services, long-term services and supports, and prescription drugs you will get and how you will get them.

You will have a comprehensive re-assessment when necessary, but at least every six months. Within 30 days of the comprehensive re-assessment, your IDT will work with you to update your PCSP. At any time, you may request a new assessment or an update to your PCSP by calling your Care Manager.

H. Does GuildNet Gold Plus FIDA Plan have a monthly plan premium?

No. There is no monthly plan premium and there are no other costs for participating in GuildNet Gold Plus FIDA Plan.

I. About the Participant Handbook

This *Participant Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, call 1-800-MEDICARE (1-800-633-4227), or call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800, TTY please call 711. You may also complain about the quality of the services we provide by calling Participant Services at 1-800-815-0000.

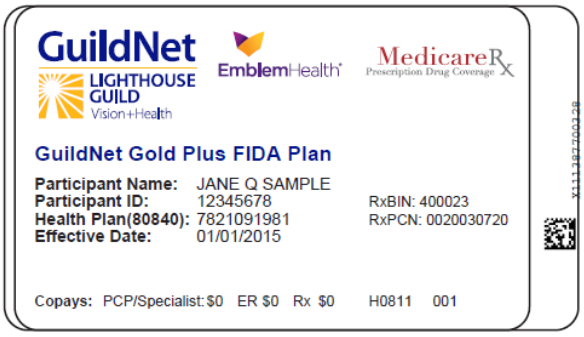
The contract is in effect for the months you are enrolled in our Plan between January 1, 2015 and December 31, 2015.

J. What other information will you get from us?

You should have already received a GuildNet Gold Plus FIDA Plan Participant ID card, a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your GuildNet Gold Plus FIDA Plan Participant ID card

Under our plan, you will have one card for your Medicare and Medicaid services, including long-term services and supports and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:


GuildNet
LIGHTHOUSE GUILD Vision+Health
EmblemHealth
MedicareRx Prescription Drug Coverage

GuildNet Gold Plus FIDA Plan

Participant Name: JANE Q SAMPLE
Participant ID: 12345678
Health Plan(80840): 7821091981
Effective Date: 01/01/2015

RxBIN: 400023
RxPCN: 0020030720

Copays: PCP/Specialist:$0 ER $0 Rx $0 H0811 001


In an emergency, call 9-1-1 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your Care Manager or the 24-Hour Nurse Advice line.

Participant Services:	1-800-815-0000	(TTY: 1-800-662-1220)
24-Hour Nurse Advice:	1-800-815-0000	(TTY: 1-800-662-1220)
Care Management:	1-800-815-0000	(TTY: 1-800-662-1220)
Pharmacy Help Desk:	1-866-557-7300	(TTY: 711)
Behavioral Health:	1-855-517-3480	(TTY: 1-855-825-2166)
Dental Providers:	1-888-468-5175	
Website:	www.guildnetny.org	

Submit Claims to: EmblemHealth/GuildNet FIDA, PO Box 2845, New York, NY 10116-2485, phone 1-866-447-9717, EDI - 13551; OR GuildNet, c/o Relay Health, 1564 Northeast Expressway, Mail Stop HQ-2361, Atlanta GA 30329, phone 1-866-775-8860; OR Behavioral Health Claims Services PO Box 803, Latham, NY 12110

If your card is damaged, lost, or stolen, call Participant Services right away and we will send you a new card.

As long as you are a Participant of our plan, you do not need to use your red, white, and blue Medicare card or your Medicaid card to get services. Keep those cards in a safe place, in case you need them later.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* is a list of the providers and pharmacies in the Plan network. While you are a Participant of our plan, you must use our Medicaid network providers to get covered services. There are some exceptions when you first join our plan, see page 7. There are also some exceptions if you cannot find a provider in our plan who can meet your needs. You will need to discuss this with your Interdisciplinary Team (IDT).

➔ You will receive an annual *Provider and Pharmacy Directory*.

➔ You can also see the *Provider and Pharmacy Directory* at www.guildnetny.org. Both Participant Services and the website can give you the most up-to-date information about changes in our network providers.

What are "network providers"?

- Network providers are doctors, nurses, health care professionals, and other providers that you can go to as a Participant of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They include home health agencies, medical equipment suppliers, personal care

services, home delivered or congregate meals, transportation, adult day centers, personal emergency response devices and other goods and services that you get through Medicare or Medicaid.

- Network providers have agreed to accept payment from our plan for covered services as payment in full. By seeing these providers, you will not have to pay anything for covered services.

- **It always is best for you to see an in-network provider,** but you may go to a provider outside of the Plan Network to get plan services covered by Medicare. A referral is not required. **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan Participants. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. There are no costs to you when you get prescriptions from network pharmacies.

Call Participant Services at 1-800-815-0000 (TTY users please call 1-800-662-1220) for more information about the *Provider and Pharmacy Directory*. You can also see the *Provider and Pharmacy Directory* at www. guildnetny.org, or download it from this website. Both Participant Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by our Plan.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.guildnetny.org or call 1-800-815-0000. TTY users please call 1-800-662-1220.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Participant Services at 1-800-815-0000. TTY users please call 1-800-662-1220.

K. How can you keep your Participant record up to date?

You can keep your Participant record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your Participant record to know what services and drugs you get**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing facility or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Participant Services at 1-800-815-0000. TTY users please call 1-800-662-1220.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8.

Chapter 2: Important phone numbers and resources

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A. How to contact GuildNet Gold Plus FIDA Plan Participant Services

CALL	1-800-815-0000 This call is free. Hours are Monday through Sunday, 8am to 8pm. We have free interpreter services for people who do not speak English.
TTY	1-800-662-1220 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours are Monday through Sunday, 8am to 8pm.
FAX	1-212-769-1621
WRITE	GuildNet Gold Plus FIDA Plan 15 West 65th Street New York, NY 10023
EMAIL	guildnetinfo@lighthouseguild.org
WEBSITE	www.guildnetny.org

Contact Participant Services about:

- **Questions about the plan**
- **Questions about claims, billing or Participant ID cards**
- **Coverage decisions about your services and items**

  A coverage decision is a decision about whether you can get certain covered services and items or how much you can have of certain covered services and items.

  Call us or your Care Manager if you have questions about a coverage decision GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) made about your services and items.

  → To learn more about coverage decisions, see Chapter 9.

- **Appeals about your services and items**

  An *appeal* is a formal way of asking us to review a decision we or your IDT made about your coverage and asking us to change it if you think we or your IDT made a mistake.

➔ To learn more about making an appeal, see Chapter 9.

- **Grievances about your services and items**

  You can file a grievance (also called "making a complaint") about us or any provider (including a non-network or network provider). A network provider is a provider who works with GuildNet Gold Plus FIDA Plan. You can also file a grievance about the quality of the care you got to us or to the Quality Improvement Organization (see Section G below).

  ➔ Note: If you disagree with a coverage decision that GuildNet Gold Plus FIDA Plan or your IDT made about your services or items, you can file an appeal (see the section above).

➔ You can also send a grievance about GuildNet Gold Plus FIDA Plan right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

➔ To learn more about filing a grievance, see Chapter 9.

- **Coverage decisions about your drugs**

  A coverage decision is a decision about whether you can get certain covered drugs or how much you can have of a certain covered drug. This applies to your Part D drugs, Medicaid prescription drugs, and Medicaid over-the-counter drugs as covered by GuildNet Gold Plus FIDA Plan. See Chapter 5 and the List of Covered Drugs for more information on your drug benefits and how to get covered drugs.

  ➔ For more on coverage decisions about your prescription drugs, see Chapter 9.

- **Appeals about your drugs**

  An *appeal* is a way to ask us to change a coverage decision.

  If you would like to appeal a coverage determination or file a grievance, please call 1-866-557-7300 (TTY please use 711) or write to us at

  GuildNet Gold Plus FIDA Plan
  Attn: Grievance and Appeals
  PO Box 2807
  New York, NY 10116-2807.

  Our fax number is 1-212-510-5320.

  ➔ For more on making an appeal about your prescription drugs, see Chapter 9.

- **Grievances about your drugs**

  You can file a grievance (also called "making a complaint") about us or any pharmacy. This includes a grievance about your prescription drugs.

  → Note: If you disagree with a coverage decision about your prescription drugs, you can file an appeal (see the section above).

  You can also send a grievance about GuildNet Gold Plus FIDA Plan right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

  → For more on filing a grievance about your prescription drugs, see Chapter 9.

- **Payment for health care or drugs you already paid for**

  To learn how to ask us to pay you back, see Chapter 7.

B. How to contact your Care Manager

When you enroll in GuildNet Gold Plus FIDA Plan, you will be assigned a Care Manager. Your Care Manager will work with you, the Plan and your providers to make sure that you get the care you need. You may request to change your Care Manager at any time.

CALL	1-800-815-0000 This call is free. Hours are Monday through Sunday, 8am to 8pm. We have free interpreter services for people who do not speak English.
TTY	1-800-662-1220 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Hours are Monday through Sunday, 8am to 8pm.
FAX	1-212-769-1621
WRITE	GuildNet Gold Plus FIDA Plan 15 West 65th Street New York, NY 10023
EMAIL	guildnetinfo@lighthouseguild.org
WEBSITE	www.guildnetny.org

Contact your Care Manager about:

- **Questions about your care and covered services, items, and drugs**
- **Assistance in making and getting to appointments**
- **Questions about getting behavioral health services, transportation, and long-term services and supports (LTSS)**
- **Requests for services, items, and drugs**
- **Requests for a Comprehensive Reassessment or changes to a Person-Centered Service Plan**

C. How to contact the Nurse Advice Call Line

GuildNet Gold Plus FIDA Plan's Nurse Advice Call Line is a service available to you 24 hours a day/7 days a week. You can contact the Nurse Advice Call Line for any health-related questions you may have.

CALL	1-800-815-0000 This call is free. The Nurse Advice Call Line is available 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	1-800-662-1220 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Nurse Advice Call Line is available 24 hours a day, 7 days a week.

Contact the Nurse Advice Call Line about:

- **Immediate questions about your health**

D. How to contact the Behavioral Health Crisis Line

CALL	1-855-517-3480 This call is free. Monday through Sunday, 24 hours a day. We have free interpreter services for people who do not speak English.
TTY	1-855-825-2166 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday through Sunday, 24 hours a day.

Contact the Behavioral Health Crisis Line about:

- **Questions about behavioral health services**
- **Any issues you might be having**

E. How to contact the Enrollment Broker

New York Medicaid Choice is New York State's Enrollment Broker for the FIDA program. New York Medicaid Choice provides free counseling about your FIDA Plan options and can help you enroll or disenroll in a FIDA Plan.

New York Medicaid Choice is not connected with any insurance company, managed care plan, or FIDA Plan.

CALL	1-855-600-FIDA This call is free. The Enrollment Broker is available Monday through Friday from 8:30 am to 8:00 pm, and Saturday from 10:00 am to 6:00 pm.
TTY	1-888-329-1541 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	New York Medicaid Choice P.O. Box 5081 New York, NY 10274
WEBSITE	http://www.nymedicaidchoice.com

Contact New York Medicaid Choice about:

- **Questions about your FIDA Plan options**

  New York Medicaid Choice counselors can:

  » help you understand your rights,

  » help you understand your FIDA Plan choices, and

  » answer your questions about changing to a new FIDA Plan.

F. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP).

HIICAP is not connected with any insurance company, managed care plan, or FIDA Plan.

CALL	1-800-701-0501 This call is free.
WEBSITE	http://www.aging.ny.gov/healthbenefits

You may also contact your local HIICAP office directly:

LOCAL OFFICE	CALL	WRITE
Nassau County	516-485-3754	Office of Children and Family Services 400 Oak Street Garden City, New York 11530
New York City	212-602-4180	Department for the Aging Two Lafayette Street, 16th Floor New York, NY 10007-1392
Suffolk County	631-853-8200	Office for the Aging H. Lee Dennison Building 100 Veterans Memorial Highway, 3rd Floor Hauppauge, NY 11788-0099
Westchester County	914-813-6651	Department of Senior Programs & Services 9 South First Avenue, 10th Floor Mt. Vernon, NY 10550

Contact HIICAP about:

- **Questions about your Medicare health insurance**

  HIICAP counselors can:

  » help you understand your rights,

  » help you understand your Medicare plan choices, and

  » answer your questions about changing to a new Medicare plan.

G. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare.Livanta is not connected with our plan.

CALL	**1-866-815-5440** This call is free. Livanta is available Monday through Friday from 9:00 am to 5:00 pm, and Saturday through Sunday from 11:00 am to 3:00 pm.
TTY	1-866-868-2289 *This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.*
WRITE	BFCC-QIO Program 9090 Junction Dr., Suite 10 Annapolis Junction, MD 20701
EMAIL	BFCCQIOArea1@livanta.com
WEBSITE	http://bfccqioarea1.com

Contact Livanta about:

- **Questions about your health care**

  You can make a complaint about the care you have received if:

  » You have a problem with the quality of care,

  » You think your hospital stay is ending too soon, ***or***

  » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

H. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

l. How to contact Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the Medicaid Helpline.

CALL	1-800-541-2831 This call is free. The Medicaid Helpline is available Monday through Friday from 8:00 am to 8:00 pm and Saturday from 9:00 am to 1:00 pm.
TTY	1-877-898-5849 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

J. How to contact the Independent Consumer Advocacy Network (ICAN)

The Independent Consumer Advocacy Network (ICAN) helps people enrolled in a FIDA Plan with access to covered services and items, questions about billing, or other questions and problems. They can help you file a grievance or an appeal with our plan.

CALL	1-844-614-8800 ICAN is available Monday through Friday, from 8am to 8pm. ICAN provides free interpreter services.
TTY	711
WEBSITE	www.icannys.org

K. How to contact the New York State Long-Term Care Ombudsman

The Long-Term Care Ombudsman Program helps people learn about nursing facilities and other long-term care settings. It also helps solve problems between these settings and residents or their families.

CALL	1-800-342-9871 This call is free.
WEBSITE	http://www.ltcombudsman.ny.gov

You may also contact your local long-term care ombudsman directly. The contact information for the ombudsman in your county can be found in the directory at the following website: http://www.ltcombudsman.ny.gov/Whois/directory.cfm.

Chapter 3: Using the plan's coverage for your health care and other covered services and items

Table of Contents

A. About "services and items," "covered services and items," "providers," and "network providers"

Services and items are health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services and items** are any of these services and items that GuildNet Gold Plus FIDA Plan pays for. Covered health care and long-term services and supports include those listed in the Covered Items and Services Chart in Chapter 4 and any other services that GuildNet Gold Plus FIDA Plan, your IDT, or an authorized provider decides are necessary for your care.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you services, medical equipment, and long-term services and supports.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you pay *nothing* for covered services or items.

B. General rules for getting your health care, behavioral health, and long-term services and supports covered by GuildNet Gold Plus FIDA Plan

GuildNet Gold Plus FIDA Plan covers all services and items covered by Medicare and Medicaid plus some additional services and items available through the FIDA Program. These include behavioral health, long term supports and services, and prescription drugs.

GuildNet Gold Plus FIDA Plan will generally pay for the services and items you need if you follow the plan rules for how to get them. To be covered:

- The care you get must be **a service or item covered by the plan.** This means that it must be included in the plan's Covered Items and Services Chart. (The chart is in Chapter 4 of this handbook). Other services and items that are not listed in the chart may also be covered if your Interdisciplinary Team (IDT) determines they are necessary for you.
- The care must be **medically necessary.** *Medically necessary* means those services and items necessary to prevent, diagnose, correct, or cure conditions you have that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- You will have and are expected to cooperate with an **Interdisciplinary Team (IDT)**. Your IDT will assess your needs, work with you and/or your designee to plan your care and services, and make sure that you receive the necessary care and services. You can find more information about the IDT in Section C.
    - In most cases, you must get approval from GuildNet Gold Plus FIDA Plan, your IDT, or an authorized provider before you can access covered services and items. This is called *prior authorization*. To learn more about prior authorization, see page 34.
    - You do not need prior authorization for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having prior authorization. To learn more about this, see page 35.
- You will have a **Care Manager** who will serve as your primary point of contact with your IDT. You can find more information about the Care Manager in Section D.
- You may choose a network provider to serve as your **Primary Care Provider (PCP).** Your PCP will also be a member of your IDT. To learn more about choosing or changing a PCP, see page 32. If you choose an out-of-network PCP, your provider must be a Medicare provider and agree to participate on your Interdisciplinary Team (IDT) to coordinate your care.
- **You must get your Medicaid-covered services and items from network providers**. Usually, GuildNet Gold Plus FIDA Plan will not cover Medicaid-covered services or items from a provider who has not joined GuildNet Gold Plus FIDA Plan's network. GuildNet Gold Plus FIDA covers out-of-network care for all Medicare-covered services. Here are some cases when this rule does not apply:

» The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 37.

» If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. To learn about getting approval to see an out-of-network provider, see page 33.

» The plan covers services and items from out-of-network providers and pharmacies when a provider or pharmacy is not available within a reasonable distance from your home.

» The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.

» When you first join the plan, you can continue seeing the providers you see now during the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later. However, your out-of-network provider must agree to provide ongoing treatment and accept payment at our rates. After the transition period, we will no longer cover

your care if you continue to see out-of-network providers for Medicaid-covered services.

» If you are a resident of a nursing facility, you can continue to live in that nursing facility for the duration of the FIDA Program, even if the nursing facility does not participate in GuildNet Gold Plus FIDA Plan's network.

» If you are receiving services from a behavioral health provider at the time of your enrollment, you may continue to get services from that provider until treatment is complete, but not for more than two years.

» The Plan covers Medicare-covered services provided by out-of-network Medicare providers. Your out-of-network provider must agree to bill our Plan for services. If you go to an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

C. Your Interdisciplinary Team (IDT)

Every Participant has an Interdisciplinary Team (IDT). Your IDT will include the following individuals:

- You and your designee(s);
- Your Care Manager
- Your Primary Care Provider (PCP) or a designee from your PCP's practice who has clinical experience and knowledge of your needs;
- Your Behavioral Health (BH) Professional, if you have one, or a designee from your BH Professional's practice who has clinical experience and knowledge of your needs;
- Your home care aide(s), or a designee with clinical experience from the home care agency who has knowledge of your needs, if you are receiving home care and approve the home care aide/designee's participation on the IDT;
- A clinical representative from your nursing facility, if receiving nursing facility care; and
- Additional individuals including:
  - » Other providers either as requested by you or your designee, or as recommended by the IDT members as necessary for adequate care planning and approved by you or your designee; or
  - » The registered nurse (RN) who completed your assessment, if approved by you or your designee

The FIDA Plan Care Manager is the IDT lead. Your IDT conducts your service planning and develops your Person-Centered Service Plan (PCSP). Your IDT authorizes services in your PCSP. These decisions cannot be changed by GuildNet Gold Plus FIDA Plan.

D. Your Care Manager

What is a Care Manager?

The FIDA Plan Care Manager coordinates your Interdisciplinary Team (IDT). The Care Manager will ensure the integration of your medical, behavioral health, substance use, community-based or facility-based long-term services and supports (LTSS), and social needs. The Care Manager will coordinate these services as specified in your Person-Centered Service Plan.

Who gets a Care Manager?

All Participants have a Care Manager. Your Care Manager assignment or selection first occurs when you are enrolled in GuildNet Gold Plus FIDA Plan.

How can I contact my Care Manager?

When a Care Manager is assigned or selected, GuildNet Gold Plus FIDA Plan will provide you with contact information for your Care Manager. Participant Services can also provide this information to you at any time during your participation in GuildNet Gold Plus FIDA Plan.

How can I change my Care Manager?

You may change your Care Manager at any time, but you will have to choose from a list of GuildNet Gold Plus FIDA Plan Care Managers. If you have an existing Care Manager (from Managed Long-Term Care, or MLTC, for example), you may ask to have the same person be your FIDA Plan Care Manager. If the Care Manager is also available in the FIDA Plan and the Care Manager's caseload permits, GuildNet Gold Plus FIDA Plan must honor your request. To change Care Managers, contact Participant Services at 1-800-815-0000 (TTY 1-800-662-1220), Monday through Sunday, 8am to 8pm.

E. Getting care from Primary Care Providers, specialists, other network providers, and out-of-network providers

Getting care from a Primary Care Provider (PCP)

You must choose a Primary Care Provider (PCP) to provide and manage your care. GuildNet Gold Plus FIDA Plan will offer you the choice of at least three Primary Care Providers to select from. If you do not choose a PCP, one will be assigned to you. You can change your PCP at any time by contacting Participant Services at 1-800-815-0000 (TTY 1-800-662-1220), Monday through Sunday, 8am to 8pm.

What is a "PCP," and what does the PCP do for you?

Your Primary Care Provider (PCP) is your main doctor and will be responsible for providing many of your preventive and primary care services. Your PCP will be a part of your Interdisciplinary Team (IDT). Your PCP will participate in developing your Person-Centered Service Plan, making coverage determinations as a member of your IDT, and recommending or requesting many of the services and items your IDT or GuildNet Gold Plus FIDA Plan will authorize.

How will I get a PCP?

We will give you a choice of at least three PCPs. If you don't choose a PCP, we will assign one to you. In assigning a PCP to you, we will consider how far the PCP is from your home, any special health care needs you have, and any special language needs you have.

If you already have a PCP when you join the plan, you will be able to continue seeing that PCP during the transition period (see page 7 for more information). After the transition period, you can continue to see that PCP even if the PCP is out of network as long as the Provider accepts Medicare and agrees to participate in the FIDA Demonstration.

Can a clinic be my PCP?

No. Your PCP may not be a clinic and must be a specific type of provider that meets certain requirements. If the PCP works at a clinic and otherwise meets all criteria, that provider can be designated as a PCP.

Changing your PCP

You may change your PCP for any reason, at any time. Simply call GuildNet Gold Plus FIDA Plan and request a new PCP. The plan will process your request and tell you the effective date of the change, which will be within five business days of your request.

If your current PCP leaves our network and does not accept Medicare or otherwise becomes unavailable, GuildNet Gold Plus FIDA Plan will provide you with an opportunity to select a new PCP.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

GuildNet Gold Plus FIDA Plan or your IDT will authorize specialist visits that are appropriate for your conditions. Access to specialists must be approved by GuildNet Gold Plus FIDA Plan or your IDT through a standing authorization or through pre-approval of a fixed number of visits to the specialist. This information will be included in your Person-Centered Service Plan (PCSP).

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 15 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If a provider of Medicare-covered services leaves the network, you may continue seeing that provider as long as the provider continues participating with Medicare and agrees to bill the Plan.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please call Participant Services at 1-800-815-0000 (TTY 1-800-662-1220), Monday through Sunday, 8am to 8pm.

How to get care from out-of-network providers

If you need care that our plan covers and our network providers cannot give it to you, you can get permission from GuildNet Gold Plus FIDA Plan or your IDT to get the care from an out-of-network provider. In this situation, we will cover the care as if you got it from a network provider and at no cost to you. You do not need approval to continue seeing an out-of-network Medicare provider. However, if you wish to continue seeing an out-of-network Medicaid

provider, please call your care manager at 1-800-815-0000 (TTY 1-800-662-1220) to make your request.

Remember, when you first join the plan, you can continue seeing the providers you see now during the "transition period." In most cases, the transition period will last for 90 days or until your Person-Centered Service Plan is finalized and implemented, whichever is later. During the transition period, our Care Manager will contact you to help you find and switch to providers that are in our network. After the transition period, we will no longer pay for your care if you continue to see out-of-network providers for Medicaid-covered services, unless GuildNet Gold Plus FIDA Plan or your IDT has authorized you to continue to see the out-of-network provider.

➔ **Please note:** If you need to go to an out-of-network provider for a Medicaid-covered service, please work with GuildNet Gold Plus FIDA Plan or your IDT to get approval to see an out-of-network provider and to find one that meets applicable Medicare or Medicaid requirements. If you go to an out-of-network provider for your Medicaid services without first getting Plan or IDT approval, you may have to pay the full cost of the services you get.

➔ **You do not need authorization for out-of-network Medicare-covered services. Out-of-Network services must be provided by Medicare providers who are willing to bill the Plan. If the out-of-network provider is your PCP, s/he must be willing to participate on your Interdisciplinary Team (IDT).**

F. Getting approval for services and items that require prior authorization

Your Interdisciplinary Team (IDT) is responsible for authorizing all services and items that can be anticipated during the development of your Person-Centered Service Plan (PCSP). GuildNet Gold Plus FIDA Plan and certain authorized providers are responsible for authorizing most of the health care services and items you might need in between IDT service planning meetings and PCSP updates. These are services and items that could not have been planned or predicted and therefore were not included in your PCSP.

Services you can get without first getting authorization

In most cases, you will need approval from GuildNet Gold Plus FIDA Plan, your IDT, or certain authorized providers before seeing other providers. This approval is called "prior authorization." You can get services like the ones listed below without first getting approval:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers or out-of-network Medicare providers.

- Urgently needed care from out-of-network providers when you can't get to network providers because you are outside the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Participant Services before you leave the service area. We can help you get dialysis while you are away.)
- Immunizations, including flu shots, hepatitis B vaccinations, and pneumonia vaccinations.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams.
- Primary Care Provider (PCP) visits.
- Palliative care.
- Other preventive services.
- Services from public health agency facilities for tuberculosis screening, diagnosis and treatment, including Directly Observed Therapy (TB/DOT).
- Vision services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services.
- Dental services through Article 28 clinics operated by Academic Dental Centers.
- Cardiac rehabilitation for the first course of treatment (a Physician or RN authorization is required for courses of treatment following the first course).
- Supplemental education, wellness, and health management services.
- Additionally, if you are eligible to receive services from Indian health providers, you may see these providers without approval from GuildNet Gold Plus FIDA Plan or your IDT.

G. How to get long-term services and supports (LTSS)

Community-based LTSS are a range of medical, habilitation, rehabilitation, home care, or social services a person needs over months or years in order to improve or maintain function or health. These services are provided in the person's home or a community-based setting such as assisted-living facilities. Facility-based LTSS are services provided in a nursing facility or other long-term residential care setting.

As a Participant in GuildNet Gold Plus FIDA Plan, you will receive a comprehensive assessment of your needs, including your need for community-based or facility-based LTSS. All of your needs, as identified in your assessment, will be addressed in your Person-Centered

Service Plan (PCSP). Your PCSP will outline which LTSS you will get, from whom, and how often.

If you have a pre-existing service plan prior to your enrollment into GuildNet Gold Plus FIDA Plan, you will continue to receive any community-based or facility-based LTSS included in the pre-existing plan. Your pre-existing service plan will be honored for 90 days or until your PCSP is finalized and implemented, whichever is later.

➔ If you have questions about LTSS, contact Participant Services or your Care Manager.

H. How to get behavioral health services

Behavioral health services are a variety of services that can support mental health and substance abuse needs you may have. This support can include emotional, social, educational, vocational, peer support and recovery services, in addition to more traditional psychiatric or medical services.

As a Participant in GuildNet Gold Plus FIDA Plan, you will receive a comprehensive assessment of your needs, including your need for behavioral health services. All of your needs, as identified in your assessment, will be addressed in your Person-Centered Service Plan (PCSP). Your PCSP will outline which behavioral health services you will get, from whom, and how often.

If you are receiving services from a behavioral health provider at the time of your enrollment in GuildNet Gold Plus FIDA Plan, you may continue to get services from that provider until treatment is complete, but not for more than two years. This is the case even if the provider does not participate in GuildNet Gold Plus FIDA Plan's network. If the services you receive are covered by Medicare, you may continue to receive services from your out-of-network Medicare provider as long as you are enrolled in the Plan.

➔ If you have questions about behavioral health services, contact Participant Services or your Care Manager.

I. How to get self-directed care

You have the opportunity to direct your own services through the Consumer Directed Personal Assistance Services (CDPAS) program.

If you are chronically ill or physically disabled and have a medical need for help with activities of daily living (ADLs) or skilled nursing services, you can get services through the

CDPAS program. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. You have flexibility and freedom in choosing your caregivers.

You must be able and willing to make informed choices regarding the management of the services you receive, or have a legal guardian or designated relative or other adult able and willing to help make informed choices.

You or your designee must also be responsible for recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services, and keep payroll records.

Your Care Manager and Interdisciplinary Team (IDT) will review the CDPAS option with you during your IDT meetings. You can select this option at any time by contacting your Care Manager.

J. How to get transportation services

GuildNet Gold Plus FIDA Plan will provide you with emergency and non-emergency transportation. Your Interdisciplinary Team (IDT) will discuss your transportation needs and will plan for how to meet them. Call your Care Manager any time you need transportation to a provider in order to get covered services and items.

Transportation coverage includes a transportation attendant to accompany you somewhere, if necessary.

Transportation is also available to non-medical events or services such as religious services, community activities, or supermarkets.

K. How to get covered services when you have a medical emergency or urgent need for care

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

- placing your health in serious risk; ***or***
- serious harm to bodily functions; ***or***

- serious dysfunction of any bodily organ or part; ***or***
- if you are a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:

» There is not enough time to safely transfer you to another hospital before delivery.

» The transfer may pose a threat to your health or safety or your unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval from GuildNet Gold Plus FIDA Plan or your IDT.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, GuildNet Gold Plus FIDA Plan covers that. To learn more, see the Covered Items and Services Chart in Chapter 4.

Please note that GuildNet Gold Plus FIDA Plan does not cover emergency care outside of the United States or its territories.

If you have an emergency, your Care Manager will talk with the doctors who give you emergency care. Those doctors will tell your Care Manager when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by GuildNet Gold Plus FIDA Plan. If you get your emergency care from out-of-network providers, your Care Manager will work with your out-of-network provider or try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider for Medicaid covered services,
- you go to an out-of-network Medicare provider for Medicare covered services ***or***

- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider or an out-of-network Medicare provider for Medicare-covered services, ***and***
- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

GuildNet Gold Plus FIDA Plan also has a 24-hr nurse line, where nurse are available to answer your health questions 24 hours a day, seven days a week. You can access this service by calling 1-800-815-0000 (TTY 1-800-662-1220).

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States.

L. What if you are billed directly for the full cost of services and items covered by GuildNet Gold Plus FIDA Plan?

Providers should only bill GuildNet Gold Plus FIDA Plan for the cost of your covered services and items. If a provider sends you a bill instead of sending it to GuildNet Gold Plus FIDA Plan, you can send it to us to pay. You should not pay the bill yourself. But if you do, GuildNet Gold Plus FIDA Plan may pay you back.

➔ If you have paid for your covered services or items, or if you have gotten a bill for covered services or items, see Chapter 7 to learn what to do.

What should you do if services or items are not covered by our plan?

GuildNet Gold Plus FIDA Plan covers all services and items:

- that are medically necessary, ***and***
- that are listed in the plan's Covered Items and Services Chart or that your Interdisciplinary Team (IDT) determines are necessary for you (see Chapter 4)***, and***
- that you get by following plan rules.

➔ If you get services or items that aren't covered by GuildNet Gold Plus FIDA Plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any services or items, you have the right to ask us. If we say we will not pay for your services or items, you have the right to appeal our decision.

Chapter 9 explains what to do if you want the plan to cover a medical service or item. It also tells you how to appeal a coverage decision. You may also call Participant Services to learn more about your appeal rights.

If you disagree with a decision made by the plan, you may contact the Independent Consumer Advocacy Network (ICAN) to help you appeal the decision. ICAN provides free information and assistance. You can call ICAN at 1-844-614-8800 (TTY 711), Monday through Friday, from 8am to 8pm.

M. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare approves the study. If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from GuildNet Gold Plus FIDA Plan, your IDT, or your Primary Care Provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study. Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Manager should contact Participant Services.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

N. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled

nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- GuildNet Gold Plus FIDA Plan's coverage of services is limited to *non-religious* aspects of care.
- GuildNet Gold Plus FIDA Plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following applies:
    - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
    - You must get approval from GuildNet Gold Plus FIDA Plan or your IDT before you are admitted to the facility or your stay will not be covered.

Your hospital coverage will be covered as we described in the benefit chart in Chapter 4. The coverage for this benefit chart is unlimited.

O. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. Other types of durable medical equipment will be rented for you by GuildNet Gold Plus FIDA Plan. Examples of items that must be rented are wheelchairs, hospital beds, and continuous positive airway pressure (CPAP) devices.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of GuildNet Gold Plus FIDA Plan, however, you will not own the rented equipment, no matter how long it is rented for you.

In certain situations, we will transfer ownership of the durable medical equipment item. Call Participant Services to find out about the requirements you must meet and the papers you need to provide.

What happens if you lose your Medicaid coverage?

If you lose your Medicaid coverage and leave the FIDA Program, you will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***
- you get your Medicare benefits in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined GuildNet Gold Plus FIDA Plan, those Medicare payments do not count toward the 13 payments you would have to make after your Medicaid ends. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare. If you join a Medicare health plan (such as a Medicare Advantage plan) instead of Original Medicare, you should check with the plan about its coverage of durable medical equipment.

What happens if you change your FIDA Plan or leave FIDA and join an MLTC Plan?

If you join another FIDA Plan or a Managed Long-Term Care (MLTC) Plan, your Care Manager at your new plan will work with you to ensure that you continue to have access to the durable medical equipment you are receiving through GuildNet Gold Plus FIDA Plan.

Chapter 4: Covered Items and Services

Table of Contents

A. Understanding your covered items and services

This chapter tells you what items and services GuildNet Gold Plus FIDA Plan pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5.

Because you are a FIDA Participant, you pay nothing for your covered items and services as long as you follow GuildNet Gold Plus FIDA Plan's rules. See Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your Care Manager and/or Participant Services at 1-800-815-0000 (TTY 1-800-612-1220).

B. GuildNet Gold Plus FIDA Plan does not allow providers to charge you for covered items or services

We do not allow GuildNet Gold Plus FIDA Plan providers to bill you for covered items or services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

➔ **You should never get a bill from a provider. If you do, see Chapter 7.**

C. About the Covered Items and Services Chart

This Covered Items and Services Chart tells you which items and services GuildNet Gold Plus FIDA Plan pays for. It lists items and services in alphabetical order and explains the covered items and services.

We will pay for the items and services listed in the Covered Items and Services Chart only when the following rules are met. You do not pay anything for the items and services listed in the Covered Items and Services Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medicaid covered items and services must be provided according to the rules set by Medicare and Medicaid.
- The items and services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need items and services to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger your life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap.

- You get your Medicaid-covered care from a network provider. A network provider is a provider who works with GuildNet Gold Plus FIDA Plan. In most cases, GuildNet Gold Plus FIDA Plan will not pay for care you get from an out-of-network provider for your Medicaid-covered services, unless it is approved by your Interdisciplinary Team (IDT) or GuildNet Gold Plus FIDA Plan. Chapter 3 has more information about using network and out-of-network providers. You may use out-of-network Medicare providers for your Medicare-covered services.
- You have an Interdisciplinary Team (IDT) that will arrange and manage your care. For more information on your IDT, see Chapter 3.
- Most of the items and services listed in the Covered Items and Services Chart are covered only if your IDT, GuildNet Gold Plus FIDA Plan, or an authorized provider approves them. This is called prior authorization. The Covered Items and Services Chart tells you when an item or service does not require prior authorization.

All preventive services are covered by GuildNet Gold Plus FIDA Plan. You will see this apple 🍎 next to preventive services in the benefits chart.

D. The Covered Items and Services Chart

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Abdominal aortic aneurysm screening GuildNet Gold Plus FIDA Plan will pay only once for an ultrasound screening for people at risk. A person is at risk if he/she has a family history of abdominal aortic aneurysms or he is a man age 65 to 75 and has smoked at least 100 cigarettes in his lifetime. You must get a doctor's order for this screening at your "Welcome to Medicare" preventive visit.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Adult day health care GuildNet Gold Plus FIDA Plan will pay for adult day health care for Participants who are functionally impaired, not homebound, and who require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services. Adult day health care includes the following services: ▪ Medical ▪ Nursing ▪ Food and nutrition ▪ Social services ▪ Rehabilitation therapy ▪ Leisure time activities, which are a planned program of diverse meaningful activities ▪ Dental ▪ Pharmaceutical ▪ Other ancillary services	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
AIDS adult day health care GuildNet Gold Plus FIDA Plan will pay for AIDS adult day health care programs (ADHCP) for Participants with HIV. ADHCP includes the following services: ▪ Individual and group counseling/education provided in a structured program setting ▪ Nursing care (including triage/assessment of new symptoms) ▪ Medication adherence support ▪ Nutritional services (including breakfast and/or lunch) ▪ Rehabilitative services ▪ Substance abuse services ▪ Mental health services ▪ HIV risk reduction services	$0 This service must be obtained from an in-network provider.
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care *provider* or practitioner in a primary care setting. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by your IDT or GuildNet Gold Plus FIDA Plan. In cases that are *not* emergencies, your IDT or GuildNet Gold Plus FIDA Plan may authorize use of an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0 *Emergency services may be obtained from an out-of-network Medicare provider.* Check with Plan if your non-emergency ambulance service must be obtained from an in-network provider.
Ambulatory surgical center services GuildNet Gold Plus FIDA Plan will pay for covered surgical procedures provided at ambulatory surgical centers.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Annual wellness visit / routine physical exam If you have been in Medicare Part B for more than 12 months, you can get an annual wellness checkup. This is to develop or update a prevention plan based on your current health and risk factors. GuildNet Gold Plus FIDA Plan will pay for this once every 12 months. **Note**: You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Assertive community treatment (ACT) GuildNet Gold Plus FIDA Plan will pay for ACT services. ACT is a mobile team-based approach to delivering comprehensive and flexible treatment, rehabilitation, case management and support services to individuals in their natural living setting.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Assisted living program GuildNet Gold Plus FIDA Plan will pay for Assisted Living Program services provided in an adult home or enriched housing setting. Services include: ▪ Personal care ▪ Housekeeping ▪ Supervision ▪ Home health aides ▪ Personal emergency response services ▪ Nursing ▪ Physical, occupational, and/or speech therapy ▪ Medical supplies and equipment ▪ Adult day health care ▪ A range of home health services ▪ Case management services of a registered professional nurse	$0 This service must be obtained from an in-network provider.
Assistive technology GuildNet Gold Plus FIDA Plan will pay for physical adaptations to the private residence of the Participant or the Participant's family. The adaptations must be necessary to ensure the health, welfare, and safety of the Participant or enable the Participant to function with greater independence in the home. Covered adaptations include: ▪ Installation of ramps and grab bars ▪ Widening of doorways ▪ Modifications of bathrooms ▪ Installation of specialized electric and plumbing systems	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Bone mass measurement GuildNet Gold Plus FIDA Plan will pay for certain procedures for Participants who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. GuildNet Gold Plus FIDA Plan will pay for the services once every 24 months, or more often if they are medically necessary. GuildNet Gold Plus FIDA Plan will also pay for a doctor to look at and comment on the results. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Breast cancer screening (mammograms) GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Clinical breast exams once every 24 months This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Cardiac (heart) rehabilitation services GuildNet Gold Plus FIDA Plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Participants must meet certain conditions with a provider's order. GuildNet Gold Plus FIDA Plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) GuildNet Gold Plus FIDA Plan pays for one visit a year with your Primary care Provider (PCP) to help lower your risk for heart disease. During this visit, your doctor may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Cardiovascular (heart) disease screening and testing GuildNet Gold Plus FIDA Plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Care management (service coordination) Care management is an individually designed intervention that helps the Participant get access to needed services. These care management interventions are designed to ensure the Participant's health and welfare and increase the Participant's independence and quality of life.	$0 *This service is provided directly by the Plan.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Cervical and vaginal cancer screening GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ For all women: Pap tests and pelvic exams once every 24 months ▪ For women who are at high risk of cervical cancer: one Pap test and pelvic exam every 12 months ▪ For women who have had an abnormal Pap test and are of childbearing age: one Pap test and pelvic exam every 12 months This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Chemotherapy GuildNet Gold Plus FIDA Plan will pay for chemotherapy for cancer patients. Chemotherapy is covered when it is provided in an inpatient or outpatient unit of a hospital, a provider's office, or a freestanding clinic.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Chiropractic services GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Adjustments of the spine to correct alignment	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Colorectal cancer screening GuildNet Gold Plus FIDA Plan will pay for the following: ▪ Barium enema » Covered once every 48 months if you're 50 or over and once every 24 months if you're at high risk for colorectal cancer, when this test is used instead of a flexible sigmoidoscopy or colonoscopy. ▪ Colonoscopy » Covered once every 24 months if you're at high risk for colorectal cancer. If you aren't at high risk for colorectal cancer, Medicare covers this test once every 120 months, or 48 months after a previous flexible sigmoidoscopy. ▪ Fecal occult blood test » Covered once every 12 months if you're 50 or older. ▪ Flexible sigmoidoscopy » Covered once every 48 months for most people 50 or older. If you aren't at high risk, Medicare covers this test 120 months after a previous screening colonoscopy. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Community integration counseling GuildNet Gold Plus FIDA Plan will pay for community integration counseling. This is a counseling service provided to Participants who are coping with altered abilities and skills, a revision of long term expectations, or changes in roles in relation to significant others. This service is primarily provided in the provider's office or the Participant's home. Community integration counseling services are usually provided in one-to-one counseling sessions. However, there are times when it is appropriate to provide this service to the Participant in a family counseling or group counseling setting.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Community transitional services GuildNet Gold Plus FIDA Plan will pay for Community Transitional Services (CTS). These services help a Participant transition from living in a nursing facility to living in the community. CTS includes: ▪ The cost of moving furniture and other belongings ▪ Buying certain essential items such as linen and dishes ▪ Security deposits, including broker's fees required to obtain a lease on an apartment or home ▪ Buying essential furnishings ▪ Set-up fees or deposits for utility or service access (for example, telephone, electricity, or heating) ▪ Health and safety assurances such as pest removal, allergen control, or one time cleaning prior to occupancy CTS cannot be used to purchase diversional or recreational items, such as televisions, VCRs/DVDs, or music systems.	$0 This service must be obtained from an in-network provider**.**
Consumer directed personal assistance services (CDPAS) GuildNet Gold Plus FIDA Plan will pay for CDPAS, which provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Services can include any of the services provided by a personal care aide (home attendant), home health aide, or nurse. Participants who choose CDPAS have flexibility and freedom to choose their caregivers. The Participant or the person acting on the Participant's behalf (such as the parent of a disabled or chronically ill child) is responsible for recruiting, hiring, training, supervising, and, if necessary, terminating caregivers providing CDPAS services.	$0 For more information on obtaining this benefit, please call Participant Services.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Continuing day treatment GuildNet Gold Plus FIDA Plan will pay for continuing day treatment. This service helps Participants maintain or enhance current levels of functioning and skills, maintain community living, and develop self-awareness and self-esteem. Services include: ▪ Assessment and treatment planning ▪ Discharge planning ▪ Medication therapy ▪ Medication education ▪ Case management ▪ Health screening and referral ▪ Rehabilitative readiness development ▪ Psychiatric rehabilitative readiness determination and referral ▪ Symptom management	$0 This service must be obtained from an in-network provider**.**
Day treatment GuildNet Gold Plus FIDA Plan will pay for six (6) months of day treatment. Day treatment is a combination of diagnostic, treatment, and rehabilitative procedures that provide the services of the clinic treatment program, as well as social training, task and skill training, and socialization activities.	$0 This service must be obtained from an in-network provider.
Defibrillator (implantable automatic) GuildNet Gold Plus FIDA Plan will pay for defibrillators for certain people diagnosed with heart failure, depending on whether the surgery takes place in a hospital inpatient or outpatient setting.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Dental services GuildNet Gold Plus FIDA Plan will pay for the following dental services: ▪ Oral exams once every six months ▪ Cleaning once every six months ▪ Dental x-rays once every six months ▪ Diagnostic services ▪ Restorative services ▪ Endodontics, periodontics, and extractions ▪ Dental prosthetics and orthotic appliances required to alleviate a serious condition, including one that affects a Participant's employability ▪ Other oral surgery ▪ Dental emergencies ▪ Other necessary dental care Oral exams and cleanings require prior authorization by the plan or your IDT. X-rays and other dental services must be authorized by your dentist. However, dental services provided through Article 28 Clinics operated by Academic Dental Centers do not require prior authorization.	*$0* This service must be obtained from an in-network provider or by an Article 28 Clinic operated by Academic Dental Centers**.**
Depression screening GuildNet Gold Plus FIDA Plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and recommendations for additional treatments. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Diabetes screening GuildNet Gold Plus FIDA Plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: ▪ High blood pressure (hypertension) ▪ History of abnormal cholesterol and triglyceride levels (dyslipidemia) ▪ Obesity ▪ History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Diabetic self-management training, services, and supplies GuildNet Gold Plus FIDA Plan will pay for the following services for all people who have diabetes (whether they use insulin or not): ▪ Supplies to monitor your blood glucose, including the following: » A blood glucose monitor » Blood glucose test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease, GuildNet Gold Plus FIDA Plan will pay for the following: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) GuildNet Gold Plus FIDA Plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. ▪ GuildNet Gold Plus FIDA Plan will pay for training to help you manage your diabetes, in some cases.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Diagnostic testing See "Outpatient diagnostic tests and therapeutic services and supplies" in this chart.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Durable medical equipment and related supplies (For a definition of "Durable medical equipment," see Chapter 12 of this handbook) Durable medical equipment includes items such as: ▪ Wheelchairs ▪ Crutches ▪ Hospital beds ▪ Nebulizers ▪ Oxygen equipment ▪ IV infusion pumps ▪ Walkers *We will pay for all medically necessary durable medical equipment that Medicare and Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.*	*$0* Medicare covered items may be obtained from an out-of-network Medicare provider. Medicaid covered items must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Emergency care *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, ***and*** ▪ needed to treat a medical or behavioral health emergency. A *medical or behavioral health emergency* is a condition with severe symptoms, severe pain, or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: ▪ placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy; ▪ serious impairment to bodily functions; or ▪ serious dysfunction of any bodily organ or part; or ▪ serious disfigurement of such person; or ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: » There is not enough time to safely transfer the Participant to another hospital before delivery. » The transfer may pose a threat to the health or safety of the Participant or unborn child. *Coverage is within the U.S. and its territories.* This service does not require prior authorization.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, *you must have your inpatient care at the out-of-network hospital authorized*. *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Environmental modifications and adaptive devices GuildNet Gold Plus FIDA Plan will pay for internal and external physical adaptations to the home that are necessary to ensure the health, welfare, and safety of the Participant. Environmental modifications may include: ▪ Installation of ramps and grab bars ▪ Widening of doorways ▪ Modifications of bathroom facilities ▪ Installation of specialized electrical or plumbing systems to accommodate necessary medical equipment ▪ Any other modification necessary to ensure the participant's health, welfare or safety	$0 This service must be obtained from an in-network provider**.**

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Family planning exam and medical treatment ▪ Family planning lab and diagnostic tests ▪ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ▪ Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap, emergency contraception, pregnancy tests) ▪ Counseling and diagnosis of infertility, and related services ▪ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions, as part of a family planning visit ▪ Treatment for sexually transmitted infections (STIs) ▪ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ▪ Abortion These services do not require prior authorization.	*$0* These services may be obtained from an out-of-network provider.
Freestanding birth center services GuildNet Gold Plus FIDA Plan will pay for all services at freestanding birth centers.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Health and wellness education programs *GuildNet Gold Plus FIDA Plan will pay for* health and wellness education for Participants and their caregivers, which includes: ▪ Classes, support groups, and workshops ▪ Educational materials and resources ▪ Website, email, or mobile application communications These services are provided on topics including, but not limited to: heart attack and stroke prevention, asthma, living with chronic conditions, back care, stress management, healthy eating and weight management, oral hygiene, and osteoporosis. This benefit also includes annual preventive care reminders and caregiver resources. This service does not require prior authorization.	$0 This service must be obtained from an in-network provider**.**

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Hearing services GuildNet Gold Plus FIDA Plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. *H*earing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include: ▪ Hearing aid selecting, fitting, and dispensing ▪ Hearing aid checks following dispensing ▪ Conformity evaluations and hearing aid repairs ▪ Audiology services, including examinations and testing ▪ Hearing aid evaluations and hearing aid prescriptions ▪ Hearing aid products, including hearing aids, earmolds, special fittings, and replacement parts when authorized by an audiologist	$0 *Hearing and balance evaluations may be obtained from an out-of-network Medicare provider.* All other hearing services must be obtained from an in-network provider.
HIV screening GuildNet Gold Plus FIDA Plan pays for one HIV screening exam every 12 months for people who: ▪ ask for an HIV screening test, ***or*** ▪ are at increased risk for HIV infection. For women who are pregnant, GuildNet Gold Plus FIDA Plan pays for up to three HIV screening tests during a pregnancy. This service does not require prior authorization.	$0 This service may be obtained from an out-of-network Medicare provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Home and community support services (HCSS) GuildNet Gold Plus FIDA Plan will pay for HCSS for Participants who: ▪ require assistance with personal care services tasks, and ▪ whose health and welfare in the community is at risk because supervision of the Participant is required when no personal care task is being performed.	$0 This service must be obtained from an in-network provider.
Home delivered and congregate meals GuildNet Gold Plus FIDA Plan will pay for congregate and home delivered meals. This is an individually designed service that provides meals to Participants who cannot prepare or obtain nutritionally adequate meals for themselves, or when providing such meals will decrease the need for more costly supported in-home meal preparation. This benefit includes three meals a day for 52 weeks a year.	$0 This service must be obtained from an in-network provider.
Home health services Before you can get home health services, a provider must tell us you need them, and they must be provided by a home health agency. GuildNet Gold Plus FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies	$0 *Medicare covered services may be obtained from an out-of-network Medicare provider.* Services not covered by Medicare must be obtained from an in-network provider. For more information on network rules for home health services, please call Participant services.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Home infusion GuildNet Gold Plus FIDA Plan will pay for the administration of home infusion drugs and supplies.	$0 This service must be obtained from an in-network provider.
Home maintenance services GuildNet Gold Plus FIDA Plan will pay for home maintenance services. Home maintenance services include household chores and services that are required to maintain an individual's home environment in a sanitary, safe, and viable manner. Chore services are provided on two levels: ▪ Light chores – Cleaning and/or washing of windows, walls, and ceilings; snow removal and/or yard work; tacking down loose rugs and/or securing tiles; and cleaning of tile work in bath and/or kitchen. Light chores are provided when needed. ▪ Heavy-duty chores – limited to one-time-only, intensive cleaning/chore efforts, except in extraordinary situations. Heavy-duty chore services may include (but are not limited to) tasks such as scraping and/or cleaning of floor areas.	$0 This service must be obtained from an in-network provider.
Home visits by medical personnel GuildNet Gold Plus FIDA Plan will cover home visits by medical personnel to provide diagnosis, treatment, and wellness monitoring. The purpose of these home visits is to preserve the Participant's functional capacity to remain in the community. Wellness monitoring includes disease prevention, health education, and identifying health risks that can be reduced.	$0 *Medicare covered services may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Immunizations GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules GuildNet Gold Plus FIDA Plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more. These services do not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Independent living skills and training Independent Living Skills Training and Development (ILST) services are individually designed to improve or maintain the ability of the Participant to live as independently as possible in the community. ILST may be provided in the Participant's residence and in the community. Services may include assessment, training, and supervision of or assistance with: ▪ Self-care ▪ Medication management ▪ Task completion ▪ Communication skills ▪ Interpersonal skills ▪ Socialization ▪ Sensory/motor skills ▪ Mobility ▪ Community transportation skills ▪ Reduction/elimination of maladaptive behaviors ▪ Problem solving skills ▪ Money management ▪ Pre-vocational skills ▪ Ability to maintain a household	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Inpatient acute hospital care, including substance abuse and rehabilitative services GuildNet Gold Plus FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Semi-private room (or a private room if it is medically necessary) ▪ Meals, including special diets ▪ Regular nursing services ▪ Costs of special care units, such as intensive care or coronary care units ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Needed surgical and medical supplies ▪ Appliances, such as wheelchairs ▪ Operating and recovery room services ▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ Blood, including storage and administration ▪ Physician services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. ***This benefit is continued on the next page***	$0 You must get approval from GuildNet Gold Plus FIDA Plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Inpatient acute hospital care, including substance abuse and rehabilitative services (continued) If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. *Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If GuildNet Gold Plus FIDA Plan provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.*	
Inpatient mental health care GuildNet Gold Plus FIDA Plan will pay for mental health care services that require a hospital stay, including days in excess of the Medicare 190-day lifetime maximum.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Intensive psychiatric rehabilitation treatment programs GuildNet Gold Plus FIDA Plan will pay for time limited, active psychiatric rehabilitation designed to: ▪ Help a Participant form and achieve mutually agreed upon goals in living, learning, working, and social environments ▪ Intervene with psychiatric rehabilitative technologies to help a Participant overcome functional disabilities	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Kidney disease services and supplies, including End-Stage Renal Disease (ESRD) services GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Kidney disease education services to teach kidney care and help Participants make good decisions about their care. You must have stage IV chronic kidney disease, and your IDT or GuildNet Gold Plus FIDA Plan must authorize it. GuildNet Gold Plus FIDA Plan will cover up to six sessions of kidney disease education services per lifetime. ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 ▪ Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply **Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.** Kidney disease education services do not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Medical nutrition therapy This benefit is for Participants with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when *ordered* by your provider. GuildNet Gold Plus FIDA Plan will pay for three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes GuildNet Gold Plus FIDA Plan, a Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a provider's request and approval by your IDT or GuildNet Gold Plus FIDA Plan. A provider must prescribe these services and renew the request to the IDT or to GuildNet Gold Plus FIDA Plan each year if your treatment is needed in the next calendar year. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Medical social services GuildNet Gold Plus FIDA Plan will pay for medical social services, which includes the assessment of social and environmental factors related to the Participant's illness and need for care. Services include: ▪ Home visits to the individual, family, or both ▪ Visits to prepare to transfer the Participant to the community ▪ Patient and family counseling, including personal, financial, and other forms of counseling services	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. GuildNet Gold Plus FIDA Plan will pay for the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting provider, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by your IDT or GuildNet Gold Plus FIDA Plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a provider certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoisis-stimulating agents (such as Procrit®) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases ➔ **Chapter 5 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6** ***provides additional information about your outpatient prescription drug coverage.***	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Medication therapy management (MTM) services GuildNet Gold Plus FIDA Plan provides medication therapy management (MTM) services for Participants who take medications for different medical conditions. MTM programs help Participants and their providers make sure that Participants' medications are working to improve their health. ➔ **Chapter 5** ***provides additional information about MTM programs.***	*$0* *This service is provided directly by the Plan.*
Mobile mental health treatment GuildNet Gold Plus FIDA Plan will pay for mobile mental health treatment, which includes individual therapy that is provided in the home. This service is available to Participants who have a medical condition or disability that limits their ability to come into an office for regular outpatient therapy sessions.	*$0* This service must be obtained from an in-network provider.
Moving assistance GuildNet Gold Plus FIDA Plan will pay for moving assistance services. These are individually designed services intended to move a Participant's possessions and furnishings when the Participant must be moved from inadequate or unsafe housing to an environment which more adequately meets the Participant's health and welfare needs and reduces the risk of unwanted nursing facility placement. Moving assistance does not include items such as security deposits, including broker's fees required to obtain a lease on an apartment or home; set-up fees or deposits for utility or service access (for example, telephone, electricity, heating); and health and safety assurances such as pest removal, allergen control, or cleaning prior to occupancy.	*$0* This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
New York State Office of Mental Health Licensed Community Residences GuildNet Gold Plus FIDA Plan will pay for behavioral health residential programs in these settings that provide rehabilitative and supportive services. These services focus on intensive, goal-oriented intervention, within a structured program setting, to address residents' needs regarding community integration. These services also include goal-oriented interventions which focus on improving or maintaining resident skills to enable living in community housing.	*$0* This service must be obtained from an in-network provider.
Nurse advice call line GuildNet Gold Plus FIDA Plan has a nurse advice line which is a toll-free phone service that Participants can call 24 hours a day, 7 days a week. Participants can call the nurse advice line for answers to general health related questions and for assistance in accessing services through GuildNet Gold Plus FIDA Plan.	$0 *This service is provided directly by the Plan.*
Nursing facility care GuildNet Gold Plus FIDA Plan will pay for nursing facilities for Participants who need 24-hour nursing care and supervision outside of a hospital.	*$0* This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Nutrition (includes nutritional counseling and educational services) GuildNet Gold Plus FIDA Plan will pay for nutrition services provided by a qualified nutritionist. Services include: ▪ Assessment of nutritional needs and food patterns ▪ Planning for providing food and drink appropriate for the individual's physical and medical needs and environmental conditions These services do not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, GuildNet Gold Plus FIDA Plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your Care Manager or Primary Care Provider (PCP) to find out more. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Other supportive services the IDT determines are necessary GuildNet Gold Plus FIDA Plan will pay for additional supportive services or items determined by the Participant's IDT to be necessary for the Participant. This is meant to cover items or services that are not traditionally included in the Medicare or Medicaid programs but that are necessary and appropriate for the Participant. One example is GuildNet Gold Plus FIDA Plan paying for a blender to puree foods for a Participant who cannot chew.	$0

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Outpatient blood services Blood, including storage and administration, beginning with the first pint you need.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Outpatient diagnostic tests and therapeutic services and supplies GuildNet Gold Plus FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ CT scans, MRIs, EKGs and X-rays when a provider orders them as part of treatment for a medical problem ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Medically necessary clinical lab services and tests ordered by a provider to help diagnose or rule out a suspected illness or condition ▪ Blood, *including storage and administration* ▪ Other outpatient diagnostic tests	$0 *These services may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Outpatient hospital services GuildNet Gold Plus FIDA Plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. GuildNet Gold Plus FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ Labs and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial-hospitalization program, if a provider certifies that inpatient treatment would be needed without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Outpatient mental health care GuildNet Gold Plus FIDA Plan will pay for mental health services provided by: ▪ a state-licensed psychiatrist or doctor, ▪ a clinical psychologist, ▪ a clinical social worker, ▪ a clinical nurse specialist, ▪ a nurse practitioner, ▪ a physician assistant, ***or*** ▪ any other Medicare-qualified mental health care professional as allowed under applicable state laws. GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Individual therapy sessions ▪ Group therapy sessions ▪ Clinic services ▪ Day treatment ▪ Psychosocial rehab services Participants may directly access one assessment from a network provider in a twelve (12) month period without getting prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Outpatient rehabilitation services GuildNet Gold Plus FIDA Plan will pay for Physical Therapy (PT), Occupational Therapy (OT), and Speech Therapy (ST). You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. OT, PT, and ST services are limited to twenty (20) visits per therapy per calendar year except for individuals with intellectual disabilities, individuals with traumatic brain injury, and individuals under age 21.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Outpatient surgery GuildNet Gold Plus FIDA Plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Palliative care GuildNet Gold Plus FIDA Plan will pay for interdisciplinary end-of-life care and consultation with the Participant and his/her family members. These services help to prevent or relieve pain and suffering and to enhance the Participant's quality of life. Services include: ▪ Family palliative care education ▪ Pain and symptom management ▪ Bereavement services ▪ Massage therapy ▪ Expressive therapies These serviced do not require prior authorization.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Partial hospitalization Partial hospitalization is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center. Partial hospitalization is more intense than the care received in a provider or therapist's office and is an alternative to inpatient hospitalization. GuildNet Gold Plus FIDA Plan will pay for partial hospitalization to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Services include: ▪ Assessment and treatment planning ▪ Health screening and referral ▪ Symptom management ▪ Medication therapy ▪ Medication education ▪ Verbal therapy ▪ Case management ▪ Psychiatric rehabilitative readiness determination ▪ Referral and crisis intervention ***Note:*** *Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.*	$0 *This service may be obtained from an out-of-network Medicare provider.*
Peer-delivered services GuildNet Gold Plus FIDA Plan will pay for peer support services provided by a peer support provider. This is a person who assists individuals with their recovery from mental illness and substance abuse disorders.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Peer mentoring GuildNet Gold Plus FIDA Plan will pay for peer mentoring for Participants who have recently transitioned into the community from a nursing facility or during times of crisis. This is an individually designed service intended to improve the Participant's self-sufficiency, self-reliance, and ability to access needed services, goods, and opportunities in the community. This will be accomplished through education, teaching, instruction, information sharing, and self-advocacy training.	$0 This service must be obtained from an in-network provider.
Personal care services (PCS) GuildNet Gold Plus FIDA Plan will pay for PCS to assist Participants with activities such as personal hygiene, dressing, feeding, and nutritional and environmental support function tasks (meal preparation and housekeeping). PCS must be medically necessary, ordered by the Participant's physician, and provided by a qualified person according to a plan of care.	$0 This service must be obtained from an in-network provider.
Personal emergency response services (PERS) GuildNet Gold Plus FIDA Plan will pay for PERS, which is an electronic device that enables certain high-risk Participants to reach out for help during an emergency.	$0 This service must be obtained from an in-network provider.
Personalized recovery oriented services (PROS) GuildNet Gold Plus FIDA Plan will pay for PROS to assist individuals in recovery from the disabling effects of mental illness. This includes the coordinated delivery of a customized array of rehabilitation, treatment, and support services in traditional settings and in off-site locations.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Pharmacy benefits (outpatient) GuildNet Gold Plus FIDA Plan will pay for certain generic, brand, and non-prescription drugs to treat a Participant's illness or condition. Chapters 5 and 6 *provide additional information about your pharmacy benefits.*	$0 This service must be obtained from an in-network pharmacy.
Physician/provider services, including Primary Care Provider (PCP) office visits GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Medically necessary health care or surgery services given in places such as: » physician's office » certified ambulatory surgical center » hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams given by your *PCP or a specialist*, if your doctor orders it to see whether you need treatment ▪ Second opinion before a medical procedure Participants may see PCPs without first getting prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Podiatry services GuildNet Gold Plus FIDA Plan will pay for the following services: ▪ Care for medical conditions affecting lower limbs, including diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) ▪ Routine foot care for Participants with conditions affecting the legs, such as diabetes	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Positive behavioral interventions and support (PBIS) GuildNet Gold Plus FIDA Plan will pay for PBIS for Participants who have significant behavioral difficulties that jeopardize their ability to remain in the community. The primary focus of this service is to decrease the intensity and/or frequency of the targeted behaviors and to teach safer or more socially appropriate behaviors. Examples of PBIS include: ▪ Comprehensive assessment of the Participant ▪ Development and implementation of a holistic structured behavioral treatment plan ▪ Training of family, natural supports, and other providers ▪ Regular reassessment of the effectiveness of the Participant's behavioral treatment plan	$0 This service must be obtained from an in-network provider.
Preventive services GuildNet Gold Plus FIDA Plan will pay for all preventive tests and screenings covered by Medicare and Medicaid to help prevent, find, or manage a medical problem. This includes, but is not limited to, all the preventive services listed in this chart. You will see this apple next to preventive services in this chart.	$0 *These services may be obtained from an out-of-network Medicare provider.*
Private duty nursing services GuildNet Gold Plus FIDA Plan will pay for private duty nursing services covered for continuous or intermittent skilled nursing services. These services are provided in the Participant's home and are beyond what a certified home health agency can provide.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and older, GuildNet Gold Plus FIDA Plan will pay for the following services once every 12 months: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. GuildNet Gold Plus FIDA Plan will pay for the following prosthetic devices, and maybe other devices not listed here: ▪ Colostomy bags and supplies related to colostomy care ▪ Pacemakers ▪ Braces ▪ Prosthetic shoes ▪ Artificial arms and legs ▪ Breast prostheses (including a surgical brassiere after a mastectomy) ▪ Orthotic appliances and devices ▪ Support stockings ▪ Orthopedic footwear GuildNet Gold Plus FIDA Plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Pulmonary rehabilitation services GuildNet Gold Plus FIDA Plan will pay for pulmonary rehabilitation programs for Participants who have moderate to very severe chronic obstructive pulmonary disease (COPD). The Participant must have *an order approved by the IDT or GuildNet Gold Plus FIDA Plan* for pulmonary rehabilitation from the provider treating the COPD.	$0 This service must be obtained from an in-network provider.
Respiratory care services GuildNet Gold Plus FIDA Plan will pay for respiratory therapy, which is an individually designed service provided in the home. Respiratory therapy includes preventive, maintenance, and rehabilitative airway-related techniques and procedures.	$0 This service must be obtained from an in-network provider.
Respite care services GuildNet Gold Plus FIDA Plan will pay for respite care services to provide scheduled relief to non-paid supports who provide primary care and support to a Participant. The service may be provided in a 24-hour block of time as required. The primary location for this service is in the Participant's home, but respite services may also be provided in another community dwelling or facility acceptable to the Participant.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Sexually transmitted infections (STIs) screening and counseling GuildNet Gold Plus FIDA Plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A PCP or other primary care practitioner must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. GuildNet Gold Plus FIDA Plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. GuildNet Gold Plus FIDA Plan will pay for these counseling sessions as a preventive service only if they are given by a PCP. The sessions must be in a primary care setting, such as a doctor's office. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Skilled nursing facility care GuildNet Gold Plus FIDA Plan covers an unlimited number of days of Skilled Nursing Facility Care and there is no prior hospital stay required. GuildNet Gold Plus FIDA Plan will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept GuildNet Gold Plus FIDA Plan amounts for payment: ▪ A nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital	$0 *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Smoking and tobacco cessation (counseling to stop smoking or tobacco use) If you use tobacco but do not have signs or symptoms of tobacco-related disease, you use tobacco and have been diagnosed with a tobacco-related disease, or you are taking medicine that may be affected by tobacco: ▪ GuildNet Gold Plus FIDA Plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. GuildNet Gold Plus FIDA Plan will pay for smoking cessation counseling for pregnant women and women up to six months after birth. This smoking cessation counseling is in addition to benefits for prescriptions and over-the-counter smoking cessation products. This service does not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Social and environmental supports GuildNet Gold Plus FIDA Plan will pay for services and items to support a Participant's medical needs. Services may include: ▪ Home maintenance tasks ▪ Homemaker/chore services ▪ Housing improvement ▪ Respite care	$0 This service must be obtained from an in-network provider.
Social day care GuildNet Gold Plus FIDA Plan will pay for social day care for functionally impaired Participants for less than 24 hours per day. The services included in this benefit provide Participants with socialization, supervision and monitoring, personal care, and nutrition in a protective setting.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Social day care transportation GuildNet Gold Plus FIDA Plan will pay for transportation between a Participant's home and the social day care facilities.	$0 This service must be obtained from an in-network provider.
Structured day program GuildNet Gold Plus FIDA Plan will pay for structured day program services provided in an outpatient congregate setting or in the community. Services are designed to improve or maintain the Participant's skills and ability to live as independently as possible in the community. Services may include: ▪ Assessment ▪ Training and supervision to an individual with self-care ▪ Task completion ▪ Communication skills ▪ Interpersonal skills ▪ Problem-solving skills ▪ Socialization ▪ Sensory/motor skills ▪ Mobility ▪ Community transportation skills ▪ Reduction/elimination of maladaptive behaviors ▪ Money management skills ▪ Ability to maintain a household	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Substance abuse services: Opioid treatment services GuildNet Gold Plus FIDA Plan will pay for opioid treatment services to help Participants manage addiction to opiates such as heroin. Opioid treatment programs administer medication, generally methadone by prescription, along with a variety of other clinical services. These programs help Participants control the physical problems associated with opiate dependence and provide the opportunity for Participants to make major lifestyle changes over time. This service does not include Methadone Maintenance, which is available through Medicaid but not through GuildNet Gold Plus FIDA Plan.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Substance abuse services: Outpatient medically supervised withdrawal GuildNet Gold Plus FIDA Plan will pay for medical supervision of Participants that are: ▪ Undergoing mild to moderate withdrawal ▪ At risk of mild to moderate withdrawal ▪ Experiencing non-acute physical or psychiatric complications associated with their chemical dependence Services must be provided under the supervision and direction of a licensed physician.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Substance abuse services: Outpatient substance abuse services *GuildNet Gold Plus FIDA Plan will pay for outpatient substance abuse services including* individual and group visits. Participants may directly access one assessment from a network provider in a twelve (12) month period without getting prior authorization.	*$0* *This service may be obtained from an out-of-network Medicare provider.*

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Substance abuse services: Substance abuse program GuildNet Gold Plus FIDA Plan will pay for substance abuse program services to provide individually designed interventions to reduce/eliminate the use of alcohol and/or other substances by the Participant, which, if not effectively dealt with, will interfere with the individual's ability to remain in the community.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Telehealth services GuildNet Gold Plus FIDA Plan will pay for telehealth services for Participants with conditions that require frequent monitoring and/or the need for frequent physician, skilled nursing, or acute care services to reduce the need for in-office visits. Participants eligible for this service include those with the following conditions: congestive heart failure, diabetes, chronic pulmonary obstructive disease, wound care, polypharmacy, mental or behavioral problems limiting self-management, and technology-dependent care such as continuous oxygen, ventilator care, total parenteral nutrition or enteral feeding. These services do not require prior authorization.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Transportation services (emergency and non-emergency) GuildNet Gold Plus FIDA Plan will pay for emergency and non-emergency transportation. Transportation is provided for medical appointments and services. Transportation is also available for non-medical events or services, such as religious services, community activities, or supermarkets, through transportation modes including but not limited to: ▪ Taxi ▪ Bus ▪ Subway ▪ Van ▪ Medical transport ▪ Ambulance ▪ Fixed wing or airplane transport ▪ Invalid coach ▪ Livery ▪ Other means	$0 Non-emergency transportation services must be obtained from an in-network provider. For emergency transportation services, please see Ambulance section.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, ***or*** ▪ a sudden medical illness, ***or*** ▪ an injury, ***or*** ▪ a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. Urgent care does not include primary care services or services provided to treat an emergency medical condition. *This coverage is within the U.S. only.* These services do not require prior authorization.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Vision care: Eye and vision exams and eye care GuildNet Gold Plus FIDA Plan will pay for the diagnosis and treatment of visual defects, eye disease, and eye injury. This includes treatment for age-related macular degeneration. Examinations for refraction are limited to once a year unless medically necessary. For people at high risk of glaucoma, GuildNet Gold Plus FIDA Plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: ▪ people with a family history of glaucoma, ▪ people with diabetes, and ▪ African-Americans who are age 50 and older. Article 28 Clinic services may be directly accessed without prior authorization from GuildNet Gold Plus FIDA Plan or your IDT.	*$0* This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
Vision Care: Eyeglasses (lenses and frames) and contact lenses GuildNet Gold Plus FIDA Plan will pay for eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services, when authorized by an optometrist or ophthalmologist. Coverage also includes the repair or replacement of parts. Eyeglasses and contact lenses are provided once every two years unless it is medically necessary to have them more frequently or unless the glasses or contact lenses are lost, damaged or destroyed. GuildNet Gold Plus FIDA Plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) GuildNet Gold Plus FIDA Plan will also pay for corrective lenses, frames, and replacements if you need them after a cataract removal without a lens implant. Article 28 Clinic services may be directly accessed without prior authorization from GuildNet Gold Plus FIDA Plan or your IDT.	$0 This service must be obtained from an in-network provider.

Services that GuildNet Gold Plus FIDA Plan pays for	What you must pay
"Welcome to Medicare" Preventive Visit GuildNet Gold Plus FIDA Plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: ▪ a review of your health, ▪ education and counseling about the preventive services you need (including screenings and shots), and ▪ referrals for other care if you need it. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 *This service may be obtained from an out-of-network Medicare provider.*
Wellness counseling GuildNet Gold Plus FIDA Plan will pay for wellness counseling to help medically stable Participants maintain their optimal health status. A Registered Professional Nurse (RN) works with the Participant to reinforce or teach healthy habits such as the need for daily exercise, weight control, or avoidance of smoking. The RN is also able to offer support for control of diseases or disorders such as high blood pressure, diabetes, morbid obesity, asthma or high cholesterol. The RN can help the Participant to identify signs and symptoms that may require intervention to prevent further complications from the disease or disorder. These services do not require prior authorization.	$0 This service must be obtained from an in-network provider.

E. Benefits *not* covered by GuildNet Gold Plus FIDA Plan, Medicare, or Medicaid

This section tells you what kinds of benefits are excluded by GuildNet Gold Plus FIDA Plan. *Excluded* means that GuildNet Gold Plus FIDA Plan does not pay for these benefits.

The list below describes some services and items that are not covered by GuildNet Gold Plus FIDA Plan under any conditions and some that are excluded by GuildNet Gold Plus FIDA Plan only in some cases.

GuildNet Gold Plus FIDA Plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Participant Handbook*). Medicare and Medicaid will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Covered Items and Services Chart, or anywhere else in this *Participant Handbook*, **the following items and services are not covered by GuildNet Gold Plus FIDA Plan:**

- Services considered not medically necessary according to the standards of Medicare and Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by GuildNet Gold Plus FIDA Plan. See page 40 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, GuildNet Gold Plus FIDA Plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Radial keratotomy, LASIK surgery, vision therapy, and other low-vision aids.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under GuildNet Gold Plus FIDA Plan, we will reimburse the veteran for the difference. Participants are still responsible for their cost sharing amounts.

F. Benefits covered outside of GuildNet Gold Plus FIDA Plan

The following four services are not covered by GuildNet Gold Plus FIDA Plan but are available through Medicare or Medicaid. Your Interdisciplinary Team (IDT) will help you access these services.

Out of network family planning services

Out of network family planning services are paid directly by Medicaid. Services include diagnosis and all medically necessary treatment, sterilization, screening and treatment for sexually transmissible diseases, and screening for disease and pregnancy. Also included is HIV counseling and testing when provided as part of a family planning visit. Additionally, reproductive health care includes coverage of all medically necessary abortions. Fertility services are not covered.

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. This does not include opioid treatment services, which are covered by GuildNet Gold Plus FIDA Plan (see the Covered Items and Services Chart above). Facilities that provide methadone maintenance treatment do so as their principal mission and are certified by the Office of Alcohol and Substance Abuse Services (OASAS) under Title 14 NYCRR, Part 828.

Directly observed therapy for tuberculosis (TB)

Tuberculosis directly observed therapy (TB/DOT) is the direct observation of oral ingestion of TB medications to ensure patient compliance with the physician's prescribed medication regimen. While the clinical management of TB is covered under GuildNet Gold Plus FIDA Plan, TB/DOT is covered by Medicaid when provided by an approved TB/DOT provider.

Hospice services

Hospice services provided to Participants by Medicare approved hospice providers are paid directly by Medicare. Hospice is a coordinated program of home and inpatient care that provides non-curative medical and support services for persons certified by a physician to be terminally ill with a life expectancy of six (6) months or less. Hospice programs provide Participants and families with palliative and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospices are organizations which must be certified under Article 40 of the New York State Public Health Law and approved by Medicare. All services must be provided by qualified employees and volunteers of the hospice or by qualified staff through contractual arrangements to the extent permitted by Federal and State requirements. All services must be provided according to a written

plan of care, which must be incorporated into the Person-Centered Service Plan (PCSP) and reflect the changing needs of the Participant/family.

If a Participant in the FIDA Plan becomes terminally ill and receives Hospice services, he or she may remain enrolled and continue to access the FIDA Plan's benefit package. Hospice services and services covered by Medicare Parts A and B that relate to the Participant's terminal illness are paid for by Original Medicare.

For hospice services and services covered by Medicare Part A or B that relate to a Participant's terminal illness:

- The hospice provider will bill Medicare for a Participant's services. Medicare will pay for hospice services and any Medicare Part A or B services. Participants pay nothing for these services.

For services covered by Medicare Part A or B that are not related to a Participant's terminal illness (except for emergency care or urgently needed care):

- The provider will bill Medicare for a Participant's services. Medicare will pay for the services covered by Medicare Part A or B. Participants pay nothing for these services.

For services covered by GuildNet Gold Plus FIDA Plan but not covered by Medicare Part A or B:

- GuildNet Gold Plus FIDA Plan will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to a Participant's terminal illness. Participants pay nothing for these services.

For drugs that may be covered by GuildNet Gold Plus FIDA Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5.

Chapter 5: Getting your outpatient prescription drugs and other covered medications through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs and other covered medications.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Medicaid.

GuildNet Gold Plus FIDA Plan also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Covered Items and Services Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. A written prescription is required for both prescription and over-the-counter (OTC) drugs.
2. You generally must use a network pharmacy to fill your prescription unless GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) has authorized you to use an out-of-network pharmacy.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page and Chapter 9 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription or over-the-counter (OTC) drug.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up.* You can then ask GuildNet Gold Plus FIDA Plan to pay you back. If you cannot pay for the drug, contact Participant Services right away. We will do what we can to help.

➔ To learn how to ask us to pay you back, see Chapter 7.

➔ If you need help getting a prescription filled, you can contact Participant Services or your Care Manager.

What if you want to change to a different network pharmacy?

➔ If you need help changing your network pharmacy, you can contact Participant Services or your Care Manager.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility. Usually, long-term care facilities have their own pharmacies. Residents may get prescription and OTC drugs through a facility's pharmacy as long as it is part of our network. If your long-term care facility's pharmacy is not in our network, please contact your Care Manager or Participant Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Participant Services or your Care Manager.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List. Our Plan's mail-order service allows you to order up to a 90-day supply.

Our plan's mail-order service allows you to order up to a 90-day supply.

How do I fill my prescriptions by mail?

To get *order forms and* information about filling your prescriptions by mail, call the Plans Prescription Benefit Managers (PBM) Express Scripts at 1-877-866-5828, Monday through Sunday, 8am to 8pm (TTY users, please call 1-800-899-2114) or you can ask your Care Manager for assistance.

Usually, a mail-order prescription will get to you within 14 days. If your medication does not arrive in time, you can call your physician and request a prescription for your local pharmacy or call Participant Services for assistance in getting the prescription filled locally. We will arrange for a temporary supply from your local pharmacy.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the mail-order pharmacy receives from you**

   The pharmacy will automatically fill and deliver new prescriptions it receives from you.

2. New prescriptions the pharmacy receives directly from your provider's office

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills, please contact your mail-order pharmacy *14* days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can call the mail-order pharmacy at 1-877-866-5828 to let them know how to reach you.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Participant Services or your Care Manager for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a Participant of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provides 24 hour services.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network, retail or mail-order pharmacy (including high-cost and unique drugs).

- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B or some covered drugs that are administered in your doctor's office.

➔ In these cases, please check first with Participant Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription at a pharmacy not in the plan's network?

Sometimes a pharmacy that is not in the plan's network will require you to pay the full cost for the drug and seek payment from us. You can ask GuildNet Gold Plus FIDA Plan to pay you back.

➔ To learn more about this, see Chapter 7.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs covered under your Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Participant Services or your Care Manager.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.guildnetny.org. The Drug List on the website is always the most current one.
- Call Participant Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs or all over-the-counter (OTC) drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

GuildNet Gold Plus FIDA Plan will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs that would be covered under Medicare Part A or Part B are covered under our plan's medical benefit.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medicaid.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of four tiers.

- Tier 1 – Medicare Part D generic drugs
- Tier 2 – Medicare Part D brand drugs
- Tier 3 – Medicaid covered (non-Part D) prescription drugs
- Tier 4 –over-the-counter (OTC) drugs and items

All drugs and items on our Drug List have a $0 copayment.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription and covered over-the-counter (OTC) drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that the prescribing provider will have to give us or your Interdisciplinary Team (IDT) extra information, or you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks the rule should not apply to your situation, you should ask GuildNet Gold Plus Plan or your IDT to make an exception. GuildNet Gold Plus FIDA Plan or your IDT may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9.

What kinds of rules are there?

5. **Limiting use of a brand-name drug when a generic version is available**

Generally, a generic drug works the same as a brand-name drug and usually costs less. In most cases, if there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us or your IDT the medical reason that the generic drug and other covered drugs that treat the same condition will not work for you and has written "DAW" (Dispense as Written) on your prescription for a brand-name drug, then GuildNet Gold Plus FIDA Plan or your IDT will approve the brand-name drug.

6. **Getting plan or IDT approval in advance**

For some drugs, you or your doctor must get approval from the plan or your IDT before you fill your prescription. If you don't get approval, we may not cover the drug. Your IDT may approve drugs as part of your Person-Centered Service Plan (PSCP), or you can ask GuildNet Gold Plus FIDA Plan for approval.

During the first *90* days of your membership in the plan, you do not need the plan or your IDT to approve a refill request for an existing prescription, even if the drug is not on our Drug List or is limited in some way. See page 113 for more information about getting a temporary supply.

7. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, GuildNet Gold Plus FIDA Plan's rules may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

8. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit:

- how many refills you can get, ***or***
- how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Participant Services or check our website at www.guildnetny.org.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider

about getting a different drug or to ask GuildNet Gold Plus FIDA Plan or your IDT to approve the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. **The drug you have been taking:**
   - is no longer on the plan's Drug List, ***or***
   - was never on the plan's Drug List, ***or***
   - is now limited in some way.
2. **You must be in one of these situations:**
   - **You are new to the plan and do not live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first *90* days of your membership** in the plan. This temporary supply will be for up to *90* days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 90 days of medication. You must fill the prescription at a network pharmacy.
   - **You are new to the plan and live in a long-term care facility.**

     We will cover a temporary supply (or supplies) of your drug **during the first *90* days of your membership** in the plan. The total supply will be for up to *a 98-day supply* days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of *98* days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
   - **You have been in the plan for more than *90* days and live in a long-term care facility and need a supply right away.**

     We will cover one *31*-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.
   - If you are a current member in our plan and you experience a change in the level of care, such as an admission or discharge from the long-term care facility, you will be allowed an "early" refill of your medications, as needed, to assist with your transition to your new level of care.

➔ To ask for a temporary supply of a drug, call Participant Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

There may be a different drug covered by the plan that works for you. You can call Participant Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- **You can ask for an exception.**

  You and your provider can ask the Plan or your IDT to make an exception. For example, you can ask our Plan or your IDT to approve a drug even though it is not on the Drug List. Or you can ask the Plan or your IDT to approve and cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

➔ To learn more about asking for an exception, see Chapter 9.

➔ If you need help asking for an exception, you can contact Participant Services or your Care Manager.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your Care Manager or your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your Care Manager or your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9.
- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your Care Manager and your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact your Care Manager or Participant Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply or multiple temporary supplies up to *98* days when you request a refill during the first *90 days* of your membership.

If you have been a member of the plan for more than *90 days* and you need a drug that is not on our Drug List, we will cover one *31*-day supply. We will also cover one *31*-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than *31* days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your Care Manager or your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your Care Manager or your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

➔ To learn more about the hospice benefit, see Chapter 4.

G. Programs on drug safety and managing drugs

Programs to help Participants use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will notify your Care Manager and have your Interdisciplinary Team (IDT) work with your provider to correct the problem.

Programs to help Participants manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to Participants that qualify. If we have a program that fits your needs, your Interdisciplinary Team (IDT) will discuss whether you should enroll in the program.

➔ If you have any questions about these programs, please contact Participant Services or your Care Manager.

Chapter 6: Understanding the plan's drug coverage

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Introduction

This chapter discusses your outpatient drug coverage through our Plan. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Medicaid, ***and***
- drugs and items covered by the plan as additional benefits.

Because you are enrolled in the Fully Integrated Duals Advantage (FIDA) Demonstration, you have no costs for any covered drugs.

To learn more about prescription drugs, you can look in these places:

- **Our plan *List of Covered Drugs.*** We call this the "Drug List." It tells you:
  - » Which drugs our Plan pays for
  - » Which of the four tiers each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Participant Services. You can also find the Drug List on our website at www.guildnetny.org. The Drug List on the website is always the most current.
- **Chapter 5 of this Participant Handbook.** Chapter 5 *t*ells how to get your outpatient prescription drugs through our Plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our Plan.
- **Our Plan *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our Plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.

A. The Explanation of Benefits (EOB)

The Plan keeps track of your drugs and your total drug costs, including the amount Medicare pays for you.

When you get prescription drugs through the Plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what the plan paid, and what Medicare paid for you. The EOB is not a bill. It is just for your records.
- **"Year-to-date" information.** These are your drugs used during the year and the total payments made by the Plan and Medicare for you since January 1.

➔ We offer coverage of drugs not covered under Medicare. *We also pay for some over-the-counter drugs.* To find out which drugs our Plan covers, see the Drug List.

B. Keeping track of your drugs

To keep track of your drugs, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your plan ID card.

Show your GuildNet Gold Plus FIDA Plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill.

2. Make sure we have the information we need if we need to reimburse you.

You should not have to pay for any covered drugs under the Plan. In the event of a mix-up at the pharmacy or some other reason that you end up paying for a covered drug, give us copies of receipts. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our Plan benefit
- When you pay a co-pay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

➔ To learn how to ask us to pay you back for the drug, see Chapter 7.

3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Participant Services. Be sure to keep these reports.

C. A summary of your drug coverage

The plan's tiers

Tiers are groups of drugs. Every drug on the plan's Drug List is in one of four tiers. There is no cost to you for drugs on any of the tiers.

- Tier 1 drugs are generic drugs covered by Medicare.
- Tier 2 drugs are brand name drugs covered by Medicare.
- Tier 3 drugs are non-Medicare covered drugs.
- Tier 4 drugs are over-the-counter drugs.

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5 or the *Provider and Pharmacy Directory.*

Your coverage for a *one-month* *or long-term* supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 98 day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Tier 1 (*generic drugs covered by Medicare*)	*$0*	*$0*	*$0*	*$0*
Tier 2 (*brand name drugs covered by Medicare*)	*$0*	*$0*	*$0*	*$0*
Tier 3 (*non-Medicare covered drugs*)	*$0*	*$0*	*$0*	*$0*
Tier 4 (*over-the-counter drugs*)	*$0*	*$0*	*$0*	*$0*

➔ For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D. Vaccinations

Our Plan covers Medicare Part D vaccines. There are no costs for vaccinations that are covered under the Plan.

Before you get a vaccination

We recommend that you talk to your Care Manager whenever you would like to get a vaccination. Your Interdisciplinary Team (IDT) will discuss appropriate vaccinations.

It is best to use a network provider and pharmacy to get your vaccinations. If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself and for getting the shot. If you are in this situation, we recommend that you call your Care Manager first. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back.

➔ To learn how to ask us to pay you back, see Chapter 7.

Chapter 7: Asking us to pay a bill you have gotten for covered services, items, or drugs

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A. When can you ask GuildNet Gold Plus FIDA Plan to pay for your services, items, or drugs?

You should not get a bill for any in-network services, items, or drugs. Our network providers must bill GuildNet Gold Plus FIDA Plan for your services, items, and drugs already received. A *network provider* is a provider who works with the FIDA Plan.

If you get a bill for health care or drugs, **do not** pay the bill. Instead, send the bill to the Plan or your Interdisciplinary Team (IDT). To send our Plan or your IDT a bill, see page 128.

- If the services, items, or drugs are covered, the Plan will pay the provider directly.
- If the services, items, or drugs are covered and you already paid the bill, GuildNet Gold Plus FIDA Plan will pay you back. It is your right to be paid back if you paid for the services, items, or drugs.
- If the services, items, or drugs are **not** covered, our Plan or your IDT will tell you. You may appeal the decision.

➔ Contact Participant Services *or your Care Manager* if you have any questions. If you get a bill and you do not know what to do about it, Participant Services can help. You can also call if you want to give more information about a request for payment you already sent to GuildNet Gold Plus FIDA Plan or your IDT.

➔ The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance about your FIDA Plan coverage and rights. To contact ICAN, call 1-844-614-8800 (TTY 711).

Here are examples of times when you may get a bill and may need to ask GuildNet Gold Plus FIDA Plan or your IDT to decide if the plan will pay you back or pay the bill that you got:

9. **When you get emergency or urgently needed health care from an out-of-network provider**

   You should ask the provider to bill our Plan.

   - If you pay the full amount when you get the care, ask us to pay you back. Send the Plan or your IDT the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send the Plan or your IDT the bill and proof of any payment you made.
     - » If the provider should be paid, the Plan will pay the provider directly.
     - » If you have already paid for the service, we will pay you back.

10. **When a network provider sends you a bill**

    Network providers must always bill our Plan.

- Whenever you get a bill from a network provider, send us the bill. The Plan will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, send the Plan or your IDT the bill and proof of any payment you made. The Plan will pay you back for your covered services, items, and drugs.

11. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

➔ In some cases, our Plan or your IDT will approve prescriptions filled at out-of-network pharmacies. Send the Plan or your IDT a copy of your receipt when you ask our Plan to pay you back. Please see Chapter 5 to learn more about out-of-network pharmacies.

12. When you pay the full cost for a prescription because you do not have your GuildNet Gold Plus FIDA Plan ID card with you

If you do not have your plan ID card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

- Send The Plan or your IDT a copy of your receipt when you ask our Plan to pay you back.

13. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on GuildNet Gold Plus FIDA Plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - » If you do not pay for the drug but think it should be covered, you can ask for a coverage decision from the Plan or your IDT (see Chapter 9).
  - » If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision from our Plan or your IDT (see Chapter 9).
- Send the Plan or your IDT a copy of your receipt when you ask for the Plan to pay you back. In some situations, our Plan or your IDT may need to get more information from your doctor or other prescriber in order for GuildNet Gold Plus FIDA Plan to pay you back for the drug.

When you send the Plan or your IDT a request for payment, your request will be reviewed and a decision will be made as to whether the service, item, or drug should be covered.

This is called making a "coverage decision." If our Plan or your IDT decides it should be covered, the Plan will pay for the service, item, or drug. If the Plan FIDA or your IDT denies your request for payment, you can appeal the decision.

➔ To learn how to make an appeal, see Chapter 9.

B. How and where to send your request for payment

Send the Plan or your Interdisciplinary Team (IDT) your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your Care Manager for help.

Mail your request for payment together with any bills or receipts to us at this address:

GuildNet Gold Plus FIDA Plan
c/o Emblem Health Claims
PO Box 2830
New York, NY 10116-2830

You may also call the Plan to request payment. Please call our Plan at 1-800-815-0000, Monday through Sunday from 8am to 8pm. TTY/TDD users, please call 1-800-662-1220.

You must submit your claim to us within 60 days *of the date you got the service, item, or drug.*

C. GuildNet Gold Plus FIDA Plan or your IDT will make a coverage decision

When our Plan or your Interdisciplinary Team (IDT) gets your request for payment, it will be reviewed and a *coverage decision* will be made. This means that the Plan or your IDT will decide whether your health care or drug is covered by the plan. The Plan or your IDT will also decide the amount, if any, you have to pay for the health care or drug.

- The Plan or your IDT will let you know if it needs more information from you.
- If the Plan or your IDT decides that the service, item, or drug is covered and you followed all the rules, the plan will pay for it. If you have already paid for the service, item, or drug, our Plan will mail you a check for *what you paid*. If you have not paid for the service, item, or drug yet, the Plan will pay the provider directly.

➔ Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If the Plan or your IDT decides the plan should not to pay for the service, item, or drug, the plan will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

➔ To learn more about coverage decisions, see Chapter 9.

D. You can appeal the coverage decision

If you think our Plan or your Interdisciplinary Team (IDT) made a mistake in turning down your request for payment, you can ask the Plan to change the decision. This is called *making an appeal.* You can also make an appeal if you do not agree with the amount GuildNet Gold Plus FIDA Plan or your IDT decides that the plan will pay.

➔ The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9.

- If you want to make an appeal about getting paid back for a service or item, go to page 160.
- If you want to make an appeal about getting paid back for a drug, go to page 163.

➔ The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any appeals you may file with GuildNet Gold Plus FIDA Plan. To contact ICAN, call 1-844-614-8800 (TTY 711).

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a Participant of GuildNet Gold Plus FIDA Plan. GuildNet Gold Plus FIDA Plan must honor your rights.

A. You have a right to get information in a way that meets your needs

We must tell you about our Plan benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are a participant in GuildNet Gold Plus FIDA Plan. We must also tell you about all of your rights and how to exercise your rights in writing prior to the effective date of coverage.

You have the right to receive timely information about GuildNet Gold Plus FIDA Plan changes. This includes the right to receive annual updates to the Marketing, Outreach and Participant Communications materials. This also means you have the right to receive notice of any significant change in the way in which services are provided to you at least 30 days prior to the intended effective date of the change.

You have the right to have all plan options, rules, and benefits fully explained, including through the use of a qualified interpreter if needed. To get information in a way that you can understand, please call Participant Services. GuildNet Gold Plus FIDA Plan has people who can answer questions in different languages. Written materials are available in Spanish, Italian, Haitian-Creole, Chinese, Russian and Korean. We can also give you information in other formats such as Braille, audio, and large print. This information is free.

- If you are having trouble getting information from our Plan because of language problems or a disability and you want to file a grievance, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also contact Medicaid by calling the New York State Department of Health at **1-866-712-7197** for more information and help in handling a problem.

Usted tiene el derecho de recibir información en una forma que satisfaga sus necesidades

Debemos informarle sobre los beneficios de GuildNet Gold Plus FIDA Plan y sobre sus derechos en una forma que Ud. pueda entender. Debemos informarle sobre sus derechos cada año mientras Ud. sea un Participante de GuildNet Gold Plus FIDA Plan. Además, debemos informarle por escrito sobre todos sus derechos y sobre cómo ejercitar esos derechos, antes de la fecha en que su cobertura entre en vigor.

Ud. tiene el derecho a recibir puntualmente información sobre los cambios de GuildNet Gold Plus FIDA Plan. Esto incluye el derecho a recibir actualizaciones anuales de los materiales de comunicación para el participante, de alcance a la comunidad y de mercadeo. Esto significa que Ud. tiene el derecho a recibir notificaciones de cualquier cambio significativo en la forma en que se le proporcionan sus servicios, al menos 30 días antes de la fecha en que se programa del dicho cambio entre en vigor.

Ud. tiene el derecho a que se le expliquen en su totalidad todas las opciones de planes, las reglas y los beneficios, incluso mediante el uso de un intérprete calificado, si fuese necesario. Para recibir información en una forma en que Ud. pueda entenderla, sírvase llamar a la oficina de Servicios para el Participante. GuildNet Gold Plus FIDA Plan cuenta con personal que puede atender preguntas en diferentes idiomas. Los materiales impresos están disponibles en español, italiano, creole haitiano, cantonés, mandarín y coreano. Le podemos proporcionar información en otros formatos, tales como Braille, audio y con letras grandes. Esta información es gratuita.

- Si tiene problemas obteniendo información de parte de GuildNet Gold Plus FIDA Plan debido a problemas de lenguaje o alguna incapacidad y desea presentar una queja, sírvase llamar a Medicare al 1-800-MEDICARE (1-800-633-4227). Se puede llamar a este número las 24 horas del día, los 7 días de la semana. Los usuarios del sistema TTY pueden llamar al 1-877-486-2048.
- Para obtener mayor información y ayuda sobre el manejo de algún problema, también puede comunicarse con Medicaid, llamando al Departamento de Salud del Estado de Nueva York al **1-866-712-7197**.

Ou gen yon dwa pou jwenn enfòmasyon yo nan yon fason ki satisfè bezwen ou yo

Nou dwe ba ou enfòmasyon sou avantaj GuildNet Gold Plus FIDA Plan ak ak enfòmasyon sou dwa ou nan yon fason ou kapab konprann. Nou dwe fè ou konnen dwa ou chak ane ou se yon Patisipan nan GuildNet Gold Plus FIDA Plan. Nou dwe fè ou konnen tou tout dwa ou ak fason pou egzèse dwa ou alekri anvan dat pwoteksyon ou kòmanse.

Ou gen dwa pou resevwa enfòmasyon kòmsadwa sou chanjman GuildNet Gold Plus FIDA Plan. Dwa sa a gen ladan dwa pou resevwa dènye enfòmasyon yo chak ane nan dokiman Maketing, Asistans ak Kominikasyon avèk Patisipan yo. Sa vle di tou ou gen dwa pou resevwa avi sou nenpòt chanjman enpòtan nan fason nou ba ou sèvis yo omwen 30 jou anvan dat nou gen entansyon mete chanjman an anvigè.

Ou gen dwa pou jwenn eksplikasyon sou tout posiblite, règ ak avantaj plan an, ansanm avèk itilizasyon yon entèprèt kalifye si li nesesè. Pou jwenn enfòmasyon yo nan yon fason ou kapab konprann, tanpri rele Sèvis Patisipan yo. GuildNet Gold Plus FIDA Plan gen moun ki kapab reponn kesyon yo nan anpil lang diferan. Dokiman ekri yo disponib nan lang Panyòl,

Italyen, Kreyòl Ayisyen, Kantonè, Mandaren ak Koreyen. Nou kapab ba ou enfòmasyon yo nan lòt fòma tou tankou Bray, odyo ak gwo lèt. Enfòmasyon sa yo gratis.

- Si ou gen pwoblèm pou jwenn enfòmasyon yo nan GuildNet Gold Plus FIDA Plan akòz pwoblèm lang oswa akòz yon andikap, epi si ou vle fè yon doleyans pou sa, rele Medicare nan nimewo 1-800-MEDICARE (1-800-633-4227). Ou kapab rele nimewo sa a 24 èdtan pa jou, 7 jou pa semèn. Itilizatè TTY yo ta dwe rele 1-877-486-2048.
- Ou kapab kontakte Medicaid depi ou rele Depatman Sante Eta New York (New York State Department of Health) nan nimewo **1-866-712-7197** pou jwenn plis enfòmasyon ak èd pou rezoud pou pwoblèm.

Lei ha diritto a ricevere informazioni con modalità confacenti alle sue esigenze

Siamo tenuti ad informarla sui programmi di benefit GuildNet Gold Plus FIDA Plan e sui suoi diritti in modo comprensibile. Dobbiamo comunicarle i suoi diritti ogni anno in cui lei ha sottoscritto il piano GuildNet Gold Plus FIDA Plan. Inoltre dobbiamo comunicarle tutti i suoi diritti e le modalità per esercitarli per iscritto prima della data di decorrenza del piano sottoscritto.

Lei ha diritto a ricevere informazioni tempestive sui cambiamenti che riguardano GuildNet Gold Plus FIDA Plan, ad esempio, il diritto a ricevere aggiornamenti annuali ai materiali di marketing, programmi di outreach e comunicazione ai partecipanti.
In questo senso lei ha inoltre il diritto a ricevere comunicazione di eventuali cambiamenti significativi sulle modalità di erogazione dei servizi con almeno 30 giorni di preavviso sulla data di entrata in vigore del cambiamento.

Lei ha diritto a ricevere spiegazioni esaurienti su tutte le opzioni, i regolamenti ed i benefit dei piani, con l'intervento, all'occorrenza, di un interprete qualificato. Per ottenere informazioni in un modo per lei comprensibile contatti telefonicamente i Servizi dedicati ai titolari (*Participant Services*). GuildNet Gold Plus FIDA Plan dispone di personale plurilingue. La documentazione scritta è disponibile in spagnolo, italiano, creolo haitiano, cantonese, mandarino e coreano. Le informazioni sono disponibili anche in altri formati, come Braille, audio e stampa a grandi caratteri. Le informazioni sono gratuite.

- In caso di difficoltà ad ottenere le informazioni da GuildNet Gold Plus FIDA Plan a causa di problemi linguistici o disabilità, e per esprimere lamentele contattare telefonicamente Medicare al numero 1-800-MEDICARE (1-800-633-4227). Il servizio è disponibile 24 ore su 24, 7 giorni su 7. Il numero per gli abbonati TTY è 1-877-486-2048.
- Per ulteriori informazioni e per ricevere assistenza in caso di problemi è possibile contattare Medicaid anche telefonando al Dipartimento della Salute dello Stato di New York al numero **1-866-712-7197**.

여러분은 여러분께 필요한 방법으로 정보를 얻을 권리가 있습니다.

저희는 GuildNet Gold Plus FIDA Plan의 혜택과 여러분의 권리에 대해 여러분이 이해하실 수 있는 방법으로 말씀드려야 합니다. 저희는 여러분이 GuildNet Gold Plus FIDA Plan의 가입하는 해마다 여러분의 권리에 대해 말씀드려야 합니다. 저희는 또한 보장내용이 효력을 발생하는 날 이전에 서면으로 여러분의 모든 권리와 여러분의 권리를 행사하는 방법에 대해서도 말씀드려야 합니다.

여러분은 GuildNet Gold Plus FIDA Plan의 변경사항에 대해 시의적절한 정보를 받으실 권리가 있습니다. 여기에는 마케팅, 아웃리치, 가입자 연락 자료 등에 대한 연례 업데이트를 수령할 권리도 포함됩니다. 또한, 이것은 여러분에게 제공되는 서비스가 상당 부분 변경되는 경우, 여러분은 그러한 변경사항이 효력을 발생하기로 되어 있는 날로부터 최소한 30일 전에 그 변경내용에 대한 통지를 받을 권리가 있다는 뜻이기도 합니다.

여러분은 모든 플랜 옵션, 규칙, 그리고 보장혜택에 대해 충분히 설명을 들을 권리가 있습니다. 여기에는 필요한 경우 자격을 갖춘 통역을 이용할 권리도 포함됩니다. 여러분이 이해할 수 있는 방법으로 정보를 얻으시려면, 가입자 서비스(Participant Services)로 문의하십시오. GuildNet Gold Plus FIDA Plan에는 여러 다른 언어로 질문에 답해드릴 수 있는 직원들이 대기하고 있습니다. *서면 자료는 스페인어, 이탈리아어, 아이티 크레올어, 광둥어, 북경어, 한국어로 제공됩니다.* 또한, 점자, 오디오, 큰 글씨 인쇄본 등 다른 형태로도 정보를 제공해 드릴 수 있습니다. 이 정보는 무료입니다.

- 언어 문제나 장애로 인해 GuildNet Gold Plus FIDA Plan에서 정보를 얻는 데 어려움을 겪고 계시고, 불만사항을 접수하고자 하시는 경우, 1-800-MEDICARE(1-800-633-4227)로 Medicare에 전화해 주십시오. 연중무휴 하루 24시간 전화하실 수 있습니다. TTY 사용자는 1-877-486-2048로 전화하셔야 합니다.
- 또한, 문제를 처리하는데 더 자세한 정보와 도움이 필요하시면, 뉴욕주 보건국 **1-866-712-7197**로 전화하셔서 Medicaid로 연락하실 수 있습니다.

您有权以符合您需要的方式获取信息

我们必须以您可以理解的方式向您介绍 GuildNet Gold Plus FIDA 所提供的福利与您的权利。我们必须每年向您重申您作为 GuildNet Gold Plus FIDA 会员所享有的权利。我们还必须在保险生效日期之前以书面形式告知您的所有权利以及如何行使这些权利。

您有权及时收到有关 GuildNet Gold Plus FIDA 变更情况的信息。包括有权收到营销、外展和会员通讯材料的年度更新。这还意味着，您有权收到有关任何重大服务变更的通知，并且此通知将在预定的变更生效之前至少 30 天发送给您。

您有权获得有关此计划中所有可选方案、规则和福利的完整说明，包括在必要时获得符合资格的口译人员的协助。要以您可以理解的方式获取信息，请致电会员服务部。GuildNet Gold Plus FIDA
备有工作人员可以用各种不同语言解答问题。*我们提供西班牙语、意大利语、海地克里奥尔语、繁体中文、簡體中文和韩语版本的书面材料。*
我们还能够以盲文、音频和大字体等其他形式为您提供信息。这些信息是免费的。

➔ 如果您在从 GuildNet Gold Plus FIDA 获取信息时因语言问题或身体残障而遇到了困难，并且您希望提出申诉，请致电 1-800-MEDICARE (1-800-633-4227) 与联邦医疗保险联系。您可每周 7 天、每天 24 小时拨打。听障用户请致电 1-877-486-2048。

Вы имеете право получать информацию тем способом, который отвечает вашим потребностям

Мы должны сообщить вам о ваших льготах и правах в рамках плана GuildNet Gold Plus FIDA понятным для вас способом. В течение каждого года вашего участия в плане GuildNet Gold Plus FIDA, мы должны сообщить вам о ваших правах. Более того, до наступления даты действия страхового покрытия мы обязаны в письменном виде сообщить вам обо всех ваших правах и способах их осуществления.

Вы имеете право своевременно получить информацию об изменениях в плане GuildNet Gold Plus FIDA. Сюда также входит право на получение ежегодных обновлений в маркетинговых, социальных и информационных материалах для участников. Это, помимо прочего, означает, что вы имеете право получить уведомление обо всех значительных изменениях в способах предоставленных услуг, в котором предоставляются услуги для вас, как минимум, за 30 дней до установленной даты вступления в силу таких изменений.

Вы имеете право на подробное пояснение всех доступных вариантов, правил и льгот, действующих в рамках плана, в том числе при помощи услуг квалифицированного перевода, если потребуется. Чтобы получить информацию удобным для вас способом, позвоните в Отдел обслуживание участников. В плане GuildNet Gold Plus FIDA работают специалисты, которые могут ответить на вопросы на различных языках. *Письменные материалы доступны на испанском, итальянском, гаитянском креольском, кантонском, мандаринском наречии и корейском языке.* Мы также можем предоставить вам информацию в других форматах, например, в брайлевской печати, аудиоформате и изданиях с крупным шрифтом. Информация предоставляется бесплатно.

➔ Если у вас возникли проблемы с получением информации от плана GuildNet Gold Plus FIDA из-за языковых трудностей или ограниченных способностей, и вы хотите

подать жалобу, позвоните в Медикейр по телефону 1-800-MEDICARE (1-800-633-4227). Служба работает без перерывов и выходных. Лицам, использующим TTY, следует звонить по номеру 1-877-486-2048.

➔ Вы также можете обратиться в Медикейд, позвонив в Департамент здравоохранения штата Нью-Йорк по телефону **1-866-712-7197**, чтобы получить дополнительную информацию и помощь в разрешении проблем.

B. We must treat you with respect, fairness, and dignity at all times

Our Plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against Participants because of any of the following:

- Race
- Ethnicity
- National origin
- Religion
- Sex
- Sexual orientation
- Age
- Mental ability
- Behavior
- Mental or physical disability
- Health status
- Color
- Marital status
- Receipt of health care
- Use of services
- Claims experience
- Appeals
- Medical history
- Genetic information
- Evidence of insurability
- Geographic location within the service area

Under the rules of our Plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation. You have the right to not be neglected, intimidated, physically or verbally abused, mistreated, or exploited. You also have the right to be treated with consideration, respect, and full recognition of your dignity, privacy, and individuality.

We cannot deny services to you or punish you for exercising your rights. Your exercising of your rights will not negatively affect the way our Plan and its providers, New York State, or CMS provide or arrange for the provision of services to you.

➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY users call 1-800-537-7697). You can also call your local Office for Civil Rights. For New York City, please call the New York City Commission on Human Rights at 212-306-7450 or 311. Westchester residents, please call the Westchester Human Rights Commission at 914-995-7710. Suffolk residents, please call the Suffolk Human rights Commission at 631-853-5480. Nassau residents, please call the Nassau Commission on Human Rights at 516-571-3662.

➔ If you have a disability and need help getting care or reaching a provider, call Participant Services. If you have a grievance, such as a problem with wheelchair access, Participant Services can help. You can reach Participant Services at 1-800-815-0000, Monday through Sunday from 8am to 8pm. TTY users call 1-800-662-1220.

C. We must ensure that you get timely access to covered services, items, and drugs

As a Participant of GuildNet Gold Plus FIDA Plan these are your rights:

- You have the right to receive medically necessary services, items, and drugs as required to meet your needs, in a way that is sensitive to your language and culture, and that is provided in an appropriate care setting, including the home and community.
- You have the right to choose a Primary Care Provider (PCP) in GuildNet Gold Plus FIDA Plan's network. A *network provider* is a provider who works with GuildNet Gold Plus FIDA Plan. You can also ask us to have a specialist serve as your PCP. You may also choose an out-of-network PCP as long as your provider accepts Medicare, is willing to bill the plan, and agrees to participate in your Interdisciplinary Team.
  - » Call Participant Services or look in the *Provider and Pharmacy Directory* to learn which providers are accepting new patients.
- You have the right to make decisions about providers and coverage, which includes the right to choose and change providers within our network.
- You have the right to go to a gynecologist or another women's health specialist without getting a referral or prior authorization.
  - » A *referral* is approval from your Primary Care Provider to see another Provider. Referrals are not required in GuildNet Gold Plus FIDA Plan.
  - » Prior authorization means that you must get approval from your Interdisciplinary Team (IDT), GuildNet Gold Plus FIDA Plan, or another specified provider before you can get certain services, items, or drugs or see an out-of-network provider for your Medicaid-covered services.

- You have the right to access other services that do not require prior authorization, such as emergency and urgently needed care, out-of-area dialysis services, and Primary Care Provider visits. Please see Chapter 4 for more information on services requiring prior authorization and those that do not.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - » This includes the right to get timely services from specialists.

- You have the right to have telephone access to your providers through on-call services. You also have the right to access the GuildNet Gold Plus FIDA Plan Nurse Advice Call Line 24 hours a day, 7 days a week in order to obtain any needed emergency or urgent care or assistance.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to access care without facing physical barriers. This includes the right to be able to get in and out of a provider's office, including barrier-free access if you have any disabilities or other conditions limiting your mobility, in accordance with the Americans with Disabilities Act.
- You have the right to access an adequate network of primary and specialty providers who are capable of meeting your needs with respect to physical access, as well as communication and scheduling needs.
- You have the right to receive reasonable accommodations in accessing care, in interacting with GuildNet Gold Plus FIDA Plan and providers, and in receiving information about your care and coverage.
- You have the right to be told where, when, and how to get the services you need, including how to get covered benefits from out-of-network providers if the providers you need are not available in GuildNet Gold Plus FIDA Plan's network. To learn about out-of-network providers, see Chapter 3.

Chapter 9 explains what you can do if you think you are not getting your services, items, or drugs within a reasonable amount of time. Chapter 9 also tells you what you can do if we have denied coverage for your services, items, or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- You have the right to have privacy during treatment and to expect confidentiality of all records and communications.
- Your personal health information includes the information you gave us when you enrolled in GuildNet Gold Plus FIDA Plan. It also includes your conversations with your providers, your medical records, and other medical and health information.
- You have the right to get information and to control how your health information is used. We give you a written notice called the "Notice of Privacy Practice" that tells about these rights. The notice also explains how we protect the privacy of your health information.
- You have the right to request that any communication that contains protected health information from our Plan be sent by alternative means or to an alternative address.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to give Medicare and Medicaid your health and drug information. If Medicare or Medicaid releases your information for research or other uses, it will be done according to Federal laws. You have the right to request information on how your health and other information has been released by us.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

➔ If you have questions or concerns about the privacy of your personal health information, call Participant Services at 1-800-815-0000, Monday through Sunday from 8am to 8pm. TTY users call 1-800-662-1220.

E. We must give you information about GuildNet Gold Plus FIDA Plan, its network providers, and your covered services

As a Participant of GuildNet Gold Plus FIDA Plan, you have the right to get timely information and updates from us. If you do not speak English, we must give you the information free of charge in a language that you can understand. We must also provide you with a qualified interpreter, free of charge, if you need one during appointments with providers. If you have questions about GuildNet Gold Plus FIDA Plan or you are in need of interpreter services, just call us at 1-800-815-0000. This is a free service. Written materials are available in Spanish, Italian, Haitian-Creole, Chinese, Russian and Korean. We can also give you information in other formats, such as Braille, audio, and large print.

If you want any of the following, call Participant Services:

- **Information about how to choose or change plans**
- **Information about GuildNet Gold Plus FIDA Plan, including:**
  - » Financial information
  - » How the Plan has been rated by plan Participants
  - » The number of appeals made by Participants
  - » How to leave our Plan
- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change Primary Care Providers
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network

  ➔ For a list of providers and pharmacies in GuildNet Gold Plus FIDA Plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Participant Services, or visit our website at www.guildnetny.org.
- **Information about covered services, items, and drugs and about rules you must follow, including:**
  - » Services, items, and drugs covered by GuildNet Gold Plus FIDA Plan
  - » Limits to your coverage and drugs
  - » Rules you must follow to get covered services, items, and drugs
- **Information about why a service, item, or drug is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made

» Asking us to pay for a bill you have received

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services, items, or drugs. They also cannot charge you if we pay less than the provider charged us or if we don't pay them at all. You have the right to not be charged any co-payments, premiums, deductibles, or other cost-sharing. To learn what to do if a network provider tries to charge you for covered services, items, or drugs, see Chapter 7 or call Participant Services.

G. You have the right to leave GuildNet Gold Plus FIDA Plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave the Plan, you will still be in the Medicare and Medicaid programs. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. You also have the right to get your Medicaid services through other programs including the Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus, Managed Long-Term Care, or Medicaid Fee-For-Service (Original Medicaid).

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your services

You have the right to get full information from your doctors and other health care providers when you get services. You also have the right to have access to doctors and other providers who can meet your needs. This includes providers who can help you meet your health care needs, communicate with you in a way that you can understand, and provide you with services in locations that you can physically access. You may also choose to have a family member or caregiver involved in your services and treatment discussions. You have the right to appoint someone to speak for you about the care you need.

- **Know your choices.** You have the right to be told about all the kinds of treatment. You have the right to talk with and receive information from providers on all available treatment options

and alternatives, regardless of cost, and to have these options presented in a way you understand.

- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another provider before deciding on treatment.
- **You can say "no.**" You have the right to accept or refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your provider advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from GuildNet Gold Plus FIDA Plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You have the right to receive a written explanation.** If covered services, items, or drugs were denied, you have the right to get a written explanation without having to request one.
- **You can ask us to cover a service, item, or drug that was denied or is usually not covered.** Chapter 9 tells how to ask our Plan or your Interdisciplinary Team (IDT) for a coverage decision.
- **You can participate in your care planning.** As a Participant in GuildNet Gold Plus FIDA Plan, you will receive an in-person Comprehensive Assessment upon enrollment. You will also meet with your IDT to develop your Person-Centered Service Plan (PCSP) and to update it, when necessary. You have the right to request a new Comprehensive Assessment or an update to your PCSP at any time. For more information, see Chapter 1.
- **You have the right to complete and accurate information related to your health and functional status from your provider, your IDT, and the Plan.**

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your providers written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a *living will* and a *power of attorney for health care*. When you enroll in the plan, we will inform you about your right to

make an advance directive. You will also be told about this right when your Person-Centered Service Plan is updated.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your Primary Care Provider, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medicaid (including Hospitals, Skilled Nursing Facilities, New York State Health Insurance Information Counseling and Assistance Program) may also have advance directive forms. You can get a New York State Health Care Proxy form on the web at http://www.health.state.ny.us/professionals/patients/health_care_proxy/intro.htm. You can also contact Participant Services to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your Primary Care Provider. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

GuildNet Gold Plus FIDA Plan and our providers must honor your instructions. If you have signed an advance directive, and you believe that a provider did not follow the instructions in it, you may file a complaint with the New York State Department of Health Hospital Complaint Line at 1-800-804-5447 or the Managed Long Term Care Technical Assistance Center at 1-866-712-7197.

l. You have the right to ask for help

Chapter 2 contains contact numbers for many helpful resources. You have the right to ask for help without interference from our Plan. You can ask for help from agencies like the Independent Consumer Advocacy Network (ICAN) or the NY State Long Term Care Ombudsman.

- The Independent Consumer Advocacy Network (ICAN) can provide information and assistance related to your GuildNet Gold Plus FIDA Plan coverage. ICAN can be reached at 1-844-614-8800. TTY users call 711.
- The NY State Long Term Care Ombudsman can provide information and assistance regarding your rights as a resident of a long-term care facility. Call 1-800-342-9871 for information about contacting your local long-term care ombudsman.

There are other resources available to you, including those listed in Chapter 2. You have the right to ask for help from the entities listed in Chapter 2 or from any other entity you identify.

J. You have the right to file a grievance and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or file a grievance.

You have the right to get information about appeals and grievances that other Participants have filed against our Plan. To get this information, call Participant Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 136—you can get help in these ways:

- You can **call Participant Services** and file a grievance with GuildNet Gold Plus FIDA Plan as outlined in Chapter 9.
- You can **call the Health Insurance Information, Counseling and Assistance Program (HIICAP)** at 1-800-701-0501.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You can **call Medicaid** at 1-800-541-2831. TTY users call *1*-877-898-5849.
- You can **call the Independent Consumer Advocacy Network (ICAN)** at1-844-614-8800. TTY users call 711.

Under all circumstances, you have the right to file an internal grievance with GuildNet Gold Plus FIDA Plan, an external grievance with Medicare or the New York State Department of Health (NYSDOH), or an appeal of any coverage decision. The processes for filing any of these are outlined in Chapter 9.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Participant Services**.
- You can **call the Health Insurance Information, Counseling and Assistance Program (HIICAP)** at 1-800-701-0501.
- You can **contact Medicare**.
  - » You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You can **call Medicaid** at 1-800-541-2831. TTY users call *1*-877-898-5849.
- You can **call the Independent Consumer Advocacy Network (ICAN)** at 1-844-614-8800. TTY users call 711.

How to get help understanding your rights or exercising them

You can call the **Independent Consumer Advocacy Network (ICAN)** at 1-844-614-8800. TTY users call 711. ICAN provides free information and assistance. It is not affiliated with our plan.

K. You have the right to suggest changes

You have the right to recommend changes in policies and services to GuildNet Gold Plus FIDA Plan, Medicare, the New York State Department of Health, or any outside representative of your choice.

L. You also have responsibilities as a Participant of GuildNet Gold Plus FIDA Plan

As a Participant of our Plan, you have a responsibility to do the things that are listed below. If you have any questions, call Participant Services.

- **Read the *Participant Handbook* to learn what is covered and what rules you need to follow to get covered services, items, and drugs.** This includes choosing a Primary Care Provider and using network providers for Medicaid-covered covered services, items, and drugs. If you don't understand something, call Participant Services.
  - » For details about your covered services and items, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapters 5 and 6.

- **Tell us about any other health or prescription drug coverage you have.** Please call Participant Services to let us know.
  - » We are required to make sure that you are using all of your coverage options when you receive services. This is called *coordination of benefits.*
  - » For more information about coordination of benefits, see Chapter 1.
- **Tell your Primary Care Provider and other providers that you are enrolled in GuildNet Gold Plus FIDA Plan.** Show your GuildNet Gold Plus FIDA Plan ID card whenever you get services, items, or drugs.
- **Help your Primary Care Provider and other providers give you the best care.**
  - » Call your Primary Care Provider or Care Manager if you are sick or injured for direction right away. When you need emergency care from out-of-network providers, notify the Plan as soon as possible. In case of emergency, call 911.
  - » Give your providers the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - » Make sure that your Primary Care Provider and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - » If you have any questions, be sure to ask. Your providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
  - » Understand the role of your Primary Care Provider, your Care Manager, and your Interdisciplinary Team (IDT) in providing your care and arranging other health care services that you may need.
  - » Participate in the development of your Person-Centered Service Plan (PCSP) with your IDT and keep appointments or notify your Care Manager or IDT if an appointment cannot be met.
- **Be considerate.** We expect all of our Participants to respect the rights of other Participants. We also expect you to act with respect in your Primary Care Provider's office, hospitals, other providers' offices, and when dealing with our Plan employees.
- **Pay what you owe.** As a GuildNet Gold Plus FIDA Plan Participant, you are responsible for paying the full cost of any services, items, or drugs that are not covered by the plan.
  - ➔ If you disagree with your IDT's decision or our Plan's decision to not cover a service, item, or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Participant Services.

- » **If you move *outside* of our service area, you cannot be a GuildNet Gold Plus FIDA Plan Participant.** Chapter 1 tells about our service area. The Enrollment Broker can help you figure out whether you are moving outside our service area and can help you identify alternative Medicare and Medicaid coverage. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Medicaid.
- » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- **Tell us if you have any changes in your personal information, including your income or assets.** You must provide the Plan with accurate and complete information.
  - » It is important to tell us right away if you have a change in personal information such as phone number, address, marital status, additions to your family, eligibility, or other health insurance coverage.
  - » If your assets in bank accounts, cash in hand, certificates of deposit, stocks, life insurance policies, or any other assets change, please notify Participant Services and New York State.
- **Call Participant Services for help if you have any questions or concerns. Let us know about any problems immediately.**

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, grievances)

What's in this chapter?

This chapter has information about coverage decisions and your grievance and appeal rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about GuildNet Gold Plus FIDA Plan.
- You need a service, item, or drug that your Interdisciplinary Team (IDT) or GuildNet Gold Plus FIDA Plan has said GuildNet Gold Plus FIDA Plan will not pay for.
- You disagree with a decision that your IDT or GuildNet Gold Plus FIDA Plan has made about your care.
- You think your covered services and items are ending too soon.
- If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find information about what to do for your problem or concern.

If you are facing a problem with your health or long-term services and supports

You should receive the health care, drugs, and long-term services and supports that your Interdisciplinary Team (IDT) determines are necessary for your care, whether included in your Person-Centered Service Plan (PCSP) or because a need arose outside of your PCSP. If you are having a problem with your care, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. TTY users call 711 for help. This chapter will explain the different options you have for different problems and complaints, but you can always call ICAN to help guide you through your problem.

Table of Contents

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with GuildNet Gold Plus FIDA Plan or with your services or payment. These processes have been approved by Medicare and Medicaid. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What do the legal terms mean?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Coverage decision" rather than "organization determination" or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Understanding and knowing the meaning of the proper legal terms can help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Independent Consumer Advocacy Network (ICAN)

If you need help getting started, you can always call ICAN. ICAN can answer your questions and help you understand what to do to handle your problem. ICAN is not connected with GuildNet Gold Plus FIDA Plan or with any insurance company or health plan. ICAN can help you understand your rights and how to share your concerns or disagreement. ICAN can also help you in communicating your concerns or disagreement with us. The toll-free phone number for ICAN is 1-844-614-8800. TTY users call 711. The services are free.

You can get help from the State Health Insurance Assistance Program

You can also call your State Health Insurance Assistance Program (SHIP). In New York State, the SHIP is called the Health Insurance Information, Counseling, and Assistance Program (HIICAP).The HIICAP counselors can answer your questions and help you understand what to do to handle your problem. The HIICAP is not connected with us or with any insurance company or health plan. The HIICAP has trained counselors and services are free. The HIICAP phone number is 1-800-701-0501.

Getting help from Medicare

You can also call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Section 3: Problems with your coverage

Section 3.1: Deciding whether you should file an appeal or a grievance

If you have a problem or concern, you only need to read the parts of this chapter that describe the process for your type of concern. The chart below will help you find the right section of this chapter for appeals and grievances.

Is your problem or concern about your coverage? (This includes problems about whether particular services, items, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for services, items, or prescription drugs.)	
Yes. My problem is about coverage. Go to the next section of this chapter, **Section 4, "Coverage decisions and appeals."**	**No.** My problem is <u>not</u> about coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to file a grievance."**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

What is a coverage decision?

A *coverage decision* is an initial decision your Interdisciplinary Team (IDT), GuildNet Gold Plus FIDA Plan, or an authorized specialist makes about your benefits and coverage or about the amount GuildNet Gold Plus FIDA Plan will pay for your medical services, items, or drugs. Your IDT, GuildNet Gold Plus FIDA Plan, or your authorized specialist is making a coverage decision whenever it decides what is covered for you and how much GuildNet Gold Plus FIDA Plan will pay. Authorized specialists include dentists, optometrists, ophthalmologists, and audiologists.

If you or your provider is not sure if a service, item, or drug is covered by GuildNet Gold Plus FIDA Plan, either of you can ask for a coverage decision before the provider gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review a decision made by your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist and change it if you think a mistake was made. For example, your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist might decide that a service, item, or drug that you want is not covered. If you or your provider disagree with that decision, you can appeal.

➔ **Note:** You are a member of your IDT. You can appeal even if you participated in the discussions that led to the coverage decision that you wish to appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- You can call us at **Participant Services** at 1-800-815-0000.
- You can call your **Care Manager** at 1-800-815-0000.
- Call the **Independent Consumer Advocacy Network (ICAN)** for free help. The phone number is 1-844-614-8800. TTY users call 711.

- Call the **Health Insurance Information, Counseling, and Assistance Program (HIICAP)** for free help. The HIICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-701-0501.
- Talk to **your provider**. Your provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - » If you want a friend, relative, or other person to be your representative, you can either complete an "Appointment of Representative" form or you can write and sign a letter indicating who you want to be your representative.
    - o To complete an "Appointment of Representative" form, call Participant Services and ask for the form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.guildnetny.org. The form will give the person permission to act for you. You must give us a copy of the signed form; OR
    - o You can write a letter and either send it to GuildNet Gold Plus FIDA Plan or have the person listed in the letter as your representative give it GuildNet Gold Plus FIDA Plan.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not need to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** of this chapter gives you information on what to do if you have problems about services, items, and drugs (but not Medicare Part D drugs). For example, use Section 5 if:
  - o You are not getting medical care you want, and you believe that this care is covered by GuildNet Gold Plus FIDA Plan.

- The Interdisciplinary Team (IDT), GuildNet Gold Plus FIDA Plan, or authorized specialist did not approve services, items, or drugs that your provider wants to give you, and you believe that this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs in tiers 3 or 4 are not covered by Part D. See Section 6 for instructions about the Part D drug appeals process.*
- You received services or items that you think should be covered, but your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist decided that GuildNet Gold Plus FIDA Plan will not pay for this care.
- You got and paid for services or items that you thought were covered, and you want GuildNet Gold Plus FIDA Plan to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with the decision.
    - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.

- **Section 6** of this chapter gives you information about Part D drugs. For example, use this section if:
    - You want to ask GuildNet Gold Plus FIDA Plan or your IDT to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
    - You want to ask GuildNet Gold Plus FIDA Plan or your IDT to waive limits on the amount of the drug you can get.
    - You want to ask GuildNet Gold Plus FIDA Plan or your IDT to cover a drug that requires prior approval.
    - GuildNet Gold Plus FIDA Plan or your IDT did not approve your request or exception, and you or your provider think we should have.
    - You want to ask for GuildNet Gold Plus FIDA Plan to pay for a prescription drug you already bought. (This is asking GuildNet Gold Plus FIDA Plan or your IDT for a coverage decision about payment.)

- **Section 7** of this chapter gives you information on how to ask us to cover a longer inpatient hospital stay if you think the provider is discharging you too soon. Use this section if:
    - You are in the hospital and think the provider asked you to leave the hospital too soon.
- **Section 8** of this chapter gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should be using, please call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). You can also get help or information from the Independent Consumer Advocacy Network (ICAN) by calling 1-844-614-8800. TTY users call 711.

Section 5: Problems about services, items, and drugs (but not Medicare Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your coverage for your medical, behavioral health, and long term care services. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs *in tiers 3 or 4* are not covered by Part D. Use Section 6 of this chapter for information about Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. **You think GuildNet Gold Plus FIDA Plan covers a medical, behavioral health or long-term care service that you need but are not getting.**

   What you can do: You can ask the Interdisciplinary Team (IDT), GuildNet Gold Plus FIDA Plan, or authorized specialist to make a coverage decision. Go to Section 5.2 (page 157) for information on asking for a coverage decision. If you disagree with that coverage decision, you can file an appeal.

2. **The IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist did not approve care your provider wants to give you, and you think it should have.**

   What you can do: You can appeal the decision to not approve your services. Go to Section 5.3 (page 160) for information on making an appeal.

3. **You received services or items that you think the plan covers, but the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist has decided that the plan will not pay.**

What you can do: You can appeal the decision that GuildNet Gold Plus FIDA Plan will not pay. Go to Section 5.4 (page 163) for information on making an appeal.

4. **You got and paid for services or items you thought were covered, and you want GuildNet Gold Plus FIDA Plan to reimburse you for the services or items.**

   What you can do: You can ask your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist to authorize the plan to pay you back. Go to Section 5.5 (page 165) for information on asking for payment.

5. **Your coverage for a certain service is being reduced, changed, or stopped, and you disagree with the decision.**

   What you can do: You can appeal the decision to reduce, change, or stop the service.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

➔ In all cases where we tell you that the services you have been getting will be stopped, use the information in Section 5.2 of this chapter as your guide for what to do.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a medical, behavioral health or long-term care service

If there is a service or item that you feel you need, ask your Interdisciplinary Team (IDT), GuildNet Gold Plus FIDA Plan, or authorized specialist to approve that service or item for you. You can do this by contacting your Care Manager and telling him/her that you want a coverage decision. Or you can call, write, or fax us, or ask your representative or provider to contact us and ask for a coverage decision.

- You can call us at: 1-800-815-0000 TTY users call: 1-800-662-1220.
- You can fax us at: 1-212-769-1621
- You can to write us at:

  GuildNet Gold Plus FIDA Plan
  Attn: Utilization Management Department
  15 West 65th Street
  New York, NY 10023

Once you've asked, your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist will make a coverage decision.

How long does it take to get a coverage decision?

It usually takes up to 3 business days after you asked. If you do not receive a decision within 3 business days, you can appeal.

➔ Sometimes the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist needs more time to make a decision. In this case, you will receive a letter telling you that it could to take up to 3 more calendar days. The letter will explain why more time is needed.

There are three exceptions to the decision deadline described above:

- For coverage decisions about continuing or adding to your current health care services, you will receive a decision within 1 business day.
- For coverage decisions about home health care services after an inpatient hospital stay, you will receive a decision within 1 business day. However, if the day after your request is a weekend or holiday, you will receive a decision within 72 hours.
- For coverage decisions on a service or item that you already received, you will receive a decision within 14 calendar days.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask for a "fast coverage decision." If the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist approves the request, you will receive a decision **within 24 hours**.

However, sometimes the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist needs more time. In this case, you will receive a letter telling you that it could to take up to 3 more calendar days. The letter will explain why more time is needed.

> ***The legal term** for "fast coverage decision" is **"expedited determination."***

If you want to ask for a fast coverage decision, you can do one of three things:

- Call your Care Manager;
- Call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220) or fax us at 1-212-769-1621; or
- Have your provider or your representative call Participant Services.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking for coverage for medical care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you have already received.)
- You can get a fast coverage decision *only* if the standard 3 business day deadline could *seriously jeopardize your life, health, or ability to attain, maintain or regain maximum function.*
    - ➔ **If your provider says that you need a fast coverage decision, you will automatically get one.**
    - ➔ If you ask for a fast coverage decision without your provider's support, the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist will decide if you get a fast coverage decision.
        - If the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist decides that your health does not meet the requirements for a fast coverage decision, you will receive a letter. The IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist will also use the standard 3 business day deadline instead.
        - This letter will tell you that if your provider asks for the fast coverage decision, you will automatically get a fast coverage decision.
        - The letter will also tell how you can file a "fast grievance" about the decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making grievances, including fast grievances, see Section 10 of this chapter.)

If the coverage decision is *Yes*, when will I get the service or item?

You will be able to get the service or item within 3 business days (for a standard coverage decision) or 24 hours (for a fast coverage decision) of when you asked. If the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist extends the time needed to make a coverage decision, you will be able to receive the service by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, you will receive a letter explaining why. The plan or your IDT will also notify you by phone.

- If the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist says no, you have the right to ask us to reconsider – and change – the decision. You can do this by making (or

"filing") an appeal. Making an appeal means asking GuildNet Gold Plus FIDA Plan to review the decision to deny coverage.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process as described just below in Section 5.3.

Section 5.3: Level 1 Appeal for services, items, and drugs (but not Medicare Part D drugs)

What is an appeal?

An *appeal* is a formal way of asking us to review the coverage decision and change it if you think there was a mistake. If you or your provider disagree with the decision, you can appeal.

In all cases, you must start your appeal at Level 1.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to GuildNet Gold Plus FIDA Plan. GuildNet Gold Plus FIDA Plan will review your coverage decision to see if it is correct. The reviewer will be someone at GuildNet Gold Plus FIDA Plan who is not part of your Interdisciplinary Team (IDT) and was not involved in the original coverage decision. When we complete the review, we will give you our decision in writing. If you need a fast decision because of your health, we will also try to notify you by phone.

If we do not decide the Level 1 Appeal in your favor, we will automatically forward your appeal to the Integrated Administrative Hearing Office for a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your provider, or your representative must contact us. You can call us at 1-800-815-0000 (TTY: 1-800-662-1220) or you may appeal in writing. For additional details on how to reach us for appeals, see Chapter 2, page 14.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a fast appeal, you should call us at 1-800-815-0000. TTY users should call 1-800-662-1220.
- If you are asking for a standard appeal, make your appeal in writing or call us.
  - You can submit a request to the following address:

    GuildNet Gold Plus FIDA Plan
    Appeals
    15 West 65th Street
    New York, NY 10023

- You may also ask for an appeal by calling us at 1-800-815-0000. TTY users should call 1-800-662-1220.

> ***The legal term** for "fast appeal" is **"expedited appeal."***

Can someone else make the appeal for me?

Yes. Your provider can make the appeal for you. Also, someone besides your provider can make the appeal for you, but first you must complete an "Appointment of Representative" form or write and sign a letter indicating who you want to be your representative. The form or letter gives the other person permission to act for you.

- To complete an "Appointment of Representative" form, call Participant Services and ask for the form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.guildnetny.org. The form will give the person permission to act for you. You must give us a copy of the signed form; OR
- You can write a letter and either send it to GuildNet Gold Plus FIDA Plan or have the person listed in the letter as your representative give it GuildNet Gold Plus FIDA Plan.

➔ If the appeal comes from someone besides you or your provider, we must receive the completed Appointment of Representative form or letter before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal within 60 calendar days from the date on the letter that you received informing you of the coverage decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

➔ Please note: If you are appealing because you were told that a service you are getting will be changed or stopped, you have to appeal quicker if you want the plan to keep giving you that service while the appeal is in process. Read *"Will my benefits continue during Level 1 Appeals"* on page 163 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy.

Can my provider give you more information about my appeal?

Yes, you and your provider may give us more information to support your appeal.

How will GuildNet Gold Plus FIDA Plan make the appeal decision?

We take a careful look at all of the information about your request for coverage of services or items. Then, we check to see if all the rules were followed when the IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist said *No* to your request. The reviewer will be someone who is not on your IDT and was not involved in making the original decision.

If we need more information, we may ask you or your provider for it.

When will I hear about a "standard" appeal decision?

If your appeal is about Medicaid prescription drugs, we must give you our answer within 7 calendar days from the date we received the appeal. For all other appeals, we must give you our answer within 30 calendar days from the date we received the appeal. We will give you our decision sooner if your health condition requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take additional time to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take additional time to make the decision, you can file a "fast grievance" about our decision to take extra time. When you file a fast grievance, we will respond to your grievance within 24 hours.
- If we do not give you an answer to your "standard" appeal within 7 calendar days (for Medicaid prescription drug appeals) or 30 calendar days (for all other appeals), or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve the service or item within 7 calendar days after we get your Medicaid prescription drug appeal or 30 calendar days after we get your other type of appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

What happens if I ask for a "fast" appeal?

If you request a fast appeal, we will give you an answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra time to make the decision, we will send you a letter that explains why we need more time.
- If we do not give you an answer within 72 hours or by the end of the extra time (if it was taken), we will automatically send your case to Level 2 of the appeals process. You will be notified when this happens.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. The letter will tell you that we sent your case to the Integrated Administrative Hearing Office for a Level 2 Appeal. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

Will my benefits continue during Level 1 Appeals?

If your IDT, GuildNet Gold Plus FIDA Plan, or authorized specialist decided to change or stop coverage for a service, item, or drug that you have been receiving, we will send you a notice before taking the proposed action.

If you disagree with the action, you can file a Level 1 Appeal. We will continue covering the service, item, or drug if you request your Level 1 Appeal within 10 calendar days of the postmark date on our notice or by the intended effective date of the action, whichever is later.

If you meet this deadline, you can keep getting the service, item, or drug with no changes while your appeal is pending. All other services, items, or drugs (that are not the subject of your appeal) will also continue with no changes.

Section 5.4: Level 2 Appeal for services, items, and drugs (but not Medicare Part D drugs)

If GuildNet Gold Plus FIDA Plan says *No* at Level 1, what happens next?

- If we say no to part or all of your Level 1 Appeal, we will automatically send your case to Level 2 of the appeals process for review by the Integrated Administrative Hearing Office.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by the Integrated Administrative Hearing Office (IAHO). The IAHO is an independent organization that is not connected to GuildNet Gold Plus FIDA Plan. The IAHO is part of the FIDA Administrative Hearing Unit at the State Office of Temporary and Disability Assistance (OTDA).

What will happen at the Level 2 Appeal?

GuildNet Gold Plus FIDA Plan will automatically send any Level 1 denials to the IAHO for a Level 2 Appeal. GuildNet Gold Plus FIDA Plan will notify you that your case was sent to Level 2 and that the IAHO will be in touch. The notice will also provide the contact information for the IAHO in the event that you do not hear from them to schedule your Level 2 Appeal hearing. You should receive a Notice of Administrative Hearing from the IAHO at least 10 calendar days before your hearing date. Your hearing will be conducted by a Hearing Officer in-person or on the phone. You may ask GuildNet Gold Plus FIDA Plan for a copy of your case file.

Your Level 2 Appeal will either be a "standard" appeal or it will be a "fast" appeal. If you had a fast appeal at Level 1, you will automatically have a fast appeal at Level 2. Additionally, if the IAHO determines that you need a fast appeal, they will give you one. Otherwise, you will have a standard appeal.

- **Standard Level 2 Appeal:** If your standard appeal is about Medicaid prescription drugs, the IAHO must give you an answer within 7 calendar days of when it gets your appeal. For all other standard appeals, the IAHO must give you an answer within *90* calendar days from the date you asked for an appeal with GuildNet Gold Plus FIDA Plan. The IAHO will give you a decision sooner if your health condition requires it.

- **Fast Level 2 Appeal:** The IAHO must give you an answer within 72 hours of when it gets your appeal.

Will my benefits continue during Level 2 Appeals?

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 163 for information about continuing your benefits during Level 1 Appeals.

All other services, items, and drugs (that are not the subject of your appeal) will also continue without any changes.

How will I find out about the decision?

When the IAHO makes a decision, it will send you a letter that explains its decision and provides information about your further appeal rights. If you qualified for a fast appeal, the IAHO will also tell you the decision by phone.

- If the IAHO says *Yes* to part or all of what you asked for, GuildNet Gold Plus FIDA Plan must authorize the items or services immediately (within no more than 1 business day from the date of the decision).

➔ If the IAHO says *No* to part or all of what you asked for, it means that they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal." You can further appeal the IAHO's decision.

If the IAHO's decision is *No* for all or part of what I asked for, can I make another appeal?

If you disagree with the IAHO decision, you may appeal that decision further to the Medicare Appeals Council (MAC) for a Level 3 Appeal. The IAHO decision is not automatically forwarded to the MAC. Instead, you will have to request that appeal. Instructions on how to file an appeal with the MAC will be included in the IAHO's decision notice.

See Section 9 of this chapter for more information on additional levels of appeal.

Section 5.5: Payment problems

GuildNet Gold Plus FIDA Plan has rules for getting services, items, and drugs. One of the rules is that the services, items, and drugs that you receive must be covered by GuildNet Gold Plus FIDA Plan. Another rule is that you must get your services from providers that GuildNet Gold Plus FIDA Plan works with. Chapter 3 explains the rules. If you follow all of the rules, then GuildNet Gold Plus FIDA Plan will pay for your services.

If you are not sure if GuildNet Gold Plus FIDA Plan will pay for a service, ask your Care Manager. Your Care Manager will be able to tell you if GuildNet Gold Plus FIDA Plan will likely pay for your services, or if you need to ask GuildNet Gold Plus FIDA Plan for a coverage decision.

If you choose to get a service, item, or drug that is not covered by GuildNet Gold Plus FIDA Plan, or if you get a service, item, or drug from a provider that GuildNet Gold Plus FIDA Plan does not work with, then GuildNet Gold Plus FIDA Plan will not automatically pay for the service, item, or drug. In that case, you may have to pay for the services, items, and drugs yourself. If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay a bill you have gotten for covered services, items, or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

How do I ask GuildNet Gold Plus FIDA Plan to pay me back for services or items I paid for?

If you are asking to be paid back, you are asking GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) for a coverage decision. GuildNet Gold Plus FIDA Plan or your IDT will decide if the service, item, or drug you paid for is covered, and will check to see if you followed all the rules for using your coverage.

- If the services, items, or drugs you paid for are covered and you followed all the rules, we will reimburse you for the cost of those services, items, or drugs within 60 calendar days after we get your request.

  Or, if you haven't paid for the services, items, or drugs yet, we will send the payment directly to your provider. When we send the payment, it's the same as saying *Yes* to your request for a coverage decision.

- If the services, items, or drugs are *not* covered, or you did *not* follow all the rules, we will send you a letter telling you that we will not pay for the services, items, or drugs, and explaining why.

What if GuildNet Gold Plus FIDA Plan says they will not pay?

If you do not agree with GuildNet Gold Plus FIDA Plan or your IDT's decision, **you can make an appeal**. Follow the appeals process described in Section 5.3. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for services, items or drugs you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

➔ If we answer "no" to your appeal, we will automatically send your case to the Integrated Administrative Hearing Office (IAHO). We will notify you by letter if this happens.

  - If the IAHO reverses the plan's decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is *Yes* at any stage of the appeals process after Level 2, GuildNet Gold Plus FIDA Plan must send the payment you asked for to you or to the provider within 60 calendar days.

  - If the IAHO says *No* to your appeal, it means they agree with the plan's decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") You may appeal this decision to the Medicare Appeals Council, as described in Section 9 of this chapter.

Section 6: Medicare Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your coverage as a Participant of GuildNet Gold Plus FIDA Plan includes many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs *in tiers 3 or 4.* These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with *in tiers 3 or 4* follow the process in **Section 5.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) to make about your Part D drugs:

- You ask GuildNet Gold Plus FIDA Plan or your IDT to make an exception such as:
  - » Asking GuildNet Gold Plus FIDA Plan or your IDT to cover a Part D drug that is not on our *List of Covered Drugs* (Drug List).
  - » Asking GuildNet Gold Plus FIDA Plan or your IDT to waive a restriction on our coverage for a drug (such as limits on the amount of the drug you can get).
- You ask GuildNet Gold Plus FIDA Plan or your IDT if a drug is covered for you (for example, when your drug is on GuildNet Gold Plus FIDA Plan's Drug List but we require you to get approval from us before we will cover it for you).
  - » *Please note:* If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining who to contact for a coverage decision.
- You ask GuildNet Gold Plus FIDA Plan or your IDT to decide that GuildNet Gold Plus FIDA Plan must pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> ***The legal term*** *for a coverage decision about your Part D drugs is* ***"coverage determination."***

If you disagree with a coverage decision made by the plan or your IDT, you can appeal. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? You can ask the plan or your IDT make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter. Also see Sections 6.3 and 6.4.	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? You can ask the plan or your IDT for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	Do you want to ask us to pay you back for a drug you have already received and paid for? You can ask the plan or your IDT to have the plan pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking the plan to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask the plan or your Interdisciplinary Team (IDT) to make an "exception."

When you ask for an exception, your prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your prescriber can ask the plan or your IDT to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5).
   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting approval before GuildNet Gold Plus FIDA Plan will cover the drug for you. (This is sometimes called "prior authorization.")
     - » Being required to try a different drug first before GuildNet Gold Plus FIDA Plan will cover the drug you are asking for. (This is sometimes called "step therapy.")
     - » Quantity limits. For some drugs, GuildNet Gold Plus FIDA Plan limits the amount of the drug you can have.

> ***The legal term** for asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your prescriber must tell us the medical reasons

Your prescriber must give GuildNet Gold Plus FIDA Plan or your Interdisciplinary Team (IDT) a statement explaining the medical reasons for requesting an exception. The decision about the exception will be faster if you include this information from your prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, GuildNet Gold Plus FIDA Plan or your IDT will generally *not* approve your request for an exception.

GuildNet Gold Plus FIDA Plan or your IDT will say* Yes *or* No *to your request for an exception

- If GuildNet Gold Plus FIDA Plan or your IDT says *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your

provider continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If GuildNet Gold Plus FIDA Plan or your IDT says *No* to your request for an exception, you can ask for a review of the decision by making an appeal. Section 6.5 tells how to make an appeal.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax your Care Manager or Participant Services to make your request. You, your representative, or prescriber can do this. You can call Participant Services at 1-866-557-7300 (TTY: 711). You can call your Care Manager at 1-800-815-0000 (TTY: 1-800-662-1220).
- You or your prescriber or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 4 to find out how to give permission to someone else to act as your representative.

  ➔ You do not need to give your prescriber written permission to ask for a coverage decision on your behalf.

- If you want to ask for GuildNet Gold Plus FIDA Plan to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks for GuildNet Gold Plus FIDA Plan to pay you back for the cost of a drug you have paid for.

***At a glance:* How to ask for a coverage decision about a drug or payment**

Call, write, or fax your Care Manager or Participant Services. Or ask your representative or prescriber to ask for a coverage decision for you. You will get an answer on a standard coverage decision within 72 hours. You will get an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your prescriber.
- You or your prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you are requesting an exception, provide the "supporting statement." Your provider must give the plan or your Interdisciplinary Team (IDT) the medical reasons for the drug exception. We call this the "supporting statement."

  Your prescriber can fax or mail the statement to us. Or your prescriber can speak with us on the phone, and then fax or mail a statement.

If your health requires it, ask for a "fast coverage decision"

The "standard deadlines" will apply unless the plan or your IDT have agreed to use the "fast deadlines."

- A standard coverage decision means the plan or your IDT will give you an answer within 72 hours after your prescriber's statement is received.
- A fast coverage decision means the plan or your IDT will give you an answer within 24 hours after your prescriber's statement is received.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your prescriber says that your health requires a "fast coverage decision," the plan or your IDT will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your prescriber's support), the plan or your IDT will decide whether you get a fast coverage decision.

    If the plan or your IDT decides to give you a standard decision, you will get a letter telling you that. The letter will tell you how to make a complaint about the decision to give you a standard decision. You can file a "fast complaint" and get a decision within 24 hours.
  - » If the plan or your IDT decides that your medical condition does not meet the requirements for a fast coverage decision, you will be notified by letter (and the standard deadlines will be used instead).

> ***The legal term** for "fast coverage decision" is **"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If the plan or your IDT is using the fast deadlines, you will get an answer within 24 hours. This means within 24 hours after the plan or your IDT gets your request. Or, if you are asking for an exception, 24 hours after the plan or your IDT gets your prescriber's statement supporting your request. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request to the Independent Review Entity, an outside independent organization that will review your request and issue a decision.

➔ **If the answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after your request is received or your prescriber's supporting statement is received.

➔ **If the answer is *No*** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If the plan or your IDT is using the standard deadlines, you will get an answer within 72 hours after your request is received or, if you are asking for an exception, after your prescriber's supporting statement is received. You will get an answer sooner if your health requires it.
- If the plan or your IDT does not meet this deadline, we will send your request on to the Independent Review Entity for its review of the request.

➔ **If the answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours of your request or, if you are asking for an exception, your prescriber's supporting statement.

➔ **If the answer is *No*** to part or all of what you asked for, you will receive a letter explaining why. The letter will also explain how you can appeal the decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- The plan or your IDT must give you an answer within 14 calendar days after your request is received.
- If the plan or your IDT does not meet this deadline, we will send your request to the Independent Review Entity for its review of the request.

➔ **If the answer is *Yes*** to part or all of what you asked for, we will make payment to you within 14 calendar days after your request is received.

➔ **If the answer is *No*** to part or all of what you asked for, you will receive a letter explaining why. This letter will also explain how you can appeal the decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-866-557-7300 (TTY please use 711).
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice that tells you the decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal.
  - » If you wish, you and your prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision the plan or your IDT made about a drug you have not yet received, you and your prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

> ***The legal term** for "fast appeal" is **"expedited appeal."***

GuildNet Gold Plus FIDA Plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if all the rules were followed when the plan or your IDT said *No* to your request. We may contact you or your prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for:

  » If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

  » If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say *No* to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Entity other information to support your appeal.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your prescriber, or your representative can request the Level 2 Appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with GuildNet Gold Plus FIDA Plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.

- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the Independent Review Entity approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an Administrative Law Judge (ALJ).

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your hospital stay, your doctor, Interdisciplinary Team (IDT), and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date." GuildNet Gold Plus FIDA Plan's coverage of your hospital stay ends on this date.
- Your doctor, IDT, or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. There is a special, faster process for appealing hospital discharge decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 above; however, both are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with GuildNet Gold Plus FIDA Plan.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Participant Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

- You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

➔ If you need help, please call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. The call is free.

Section 7.2: Quality Improvement Organization (QIO) Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization (QIO). The QIO will do a Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make a QIO Level 1 Appeal to change your discharge date, call Livanta (the QIO for New York State) at 1-866-815-5440.

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to*

***At a glance:* How to make a QIO Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

pay all of the costs for hospital care you get after your planned discharge date.

➔ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to GuildNet Gold Plus FIDA Plan instead. For details, see Section 5 of this chapter.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). You can also call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You may also call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. TTY users call 711.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of GuildNet Gold Plus FIDA Plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal** term for "fast review" is **"immediate review."***

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your provider, and review all of the information related to your hospital stay.

> ***The legal term** for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Participant Services at **1-800-815-0000 (TTY: 1-800-662-1220)**. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users call 1-877-486-2048.) Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your provider, the hospital, and we think it is right for you to be discharged on that date.

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says No and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Quality Improvement Organization (QIO) Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach Livanta (the QIO for New York State) at 1-866-815-5440.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

What happens if the answer is *Yes*?

- We must pay you back for our share of

***At a glance:* How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state and ask for another review.

the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.

- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss the QIO Level 1 appeal deadline, you can still file an appeal directly with GuildNet Gold Plus FIDA Plan following the same process described in Section 5 above, which is also summarized below.

Level 1 Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with GuildNet Gold Plus FIDA Plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision as fast as your condition requires but no later than 72 hours after you ask for a "fast review."

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Participant Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term*** *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Appeal to change your hospital discharge date

If we do not agree with you that your hospital discharge date should be changed, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The IAHO does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The IAHO is not connected with GuildNet Gold Plus FIDA Plan.

> ***At a glance:*** **How to make a Level 2 Alternate Appeal**
>
> You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

- A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IAHO says *Yes* to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue GuildNet Gold Plus FIDA Plan's coverage of your hospital services for as long as it is medically necessary.
- If the IAHO says *No* to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled the Medicare Appeals Council (MAC). Section 9 of this chapter has more information about additional appeal levels.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

➔ With any of these three types of care, you have the right to keep getting covered services for as long as your provider or Interdisciplinary Team (IDT) says you need it.

➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your services.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. There is a special, faster process for appealing these types of coverage decisions. It is handled by the Medicare-designated Quality Improvement Organization (QIO). It is highly recommended that you use the faster process instead of the regular appeal process described in Section 5 above; however, both are available to you. This section tells you how to ask for a QIO appeal, and also reminds you about your appeal option with GuildNet Gold Plus FIDA Plan.

Section 8.1: We will tell you in advance when your coverage will be ending

- The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your services.
- The written notice tells you the date when we will stop covering your services.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with GuildNet Gold Plus FIDA Plan that it is time to stop getting services.

When your coverage ends, we will stop paying for your services.

Section 8.2: Quality Improvement Organization (QIO) Level 1 Appeal to continue your care

If you think we are ending the coverage of your services too soon, you can file an appeal. This section tells you how to ask for a Level 1 Appeal with the Quality Improvement Organization (QIO).

Before you start, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines GuildNet Gold Plus FIDA Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). Or call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.

During a QIO Level 1 Appeal, the Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

***At a glance:* How to make a QIO Level 1 Appeal to ask GuildNet Gold Plus FIDA Plan to continue your care**

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to GuildNet Gold Plus FIDA Plan instead. For details about this other way to make your appeal, see Section 8.4.

> ***The legal term*** *for the written notice is* ***"Notice of Medicare Non-Coverage."***
> *To get a sample copy, call Participant Services at 1-800-815-0000 or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.). Or see a copy online at http://www.cms.hhs.gov/BNI/*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, GuildNet Gold Plus FIDA Plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your provider, and review information that GuildNet Gold Plus FIDA Plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say *Yes*?

- If the reviewers say *Yes* to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No*?

- If the reviewers say *No* to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Quality Improvement Organization (QIO) Level 2 Appeal to continue your care

If the Quality Improvement Organization (QIO) said *No* to the QIO Level 1 Appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a QIO Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the QIO Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your QIO Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days.

***At a glance:* How to make a QIO Level 2 Appeal to require that GuildNet Gold Plus FIDA Plan cover your care for longer**

Call the Quality Improvement Organization for your state at 1-866-815-5440 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says *Yes*?

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No*?

- It means they agree with the decision they made on the QIO Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your QIO Level 1 Appeal?

If you miss the QIO Level 1 appeal deadline, you can still file an appeal directly with GuildNet Gold Plus FIDA Plan following the same process described in Section 5 above, which is also summarized below.

Level 1 Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can file an appeal with GuildNet Gold Plus FIDA Plan. Ask us for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Participant Services number and ask for a "fast review."

We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision as quickly as your condition requires but not later than 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No*** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

  » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the Integrated Administrative Hearing Office. When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term** for "fast review" or "fast appeal" is **"expedited appeal."

Level 2 Appeal to continue your care for longer

If we do not agree with you that your services should continue, we will send the information for your Level 2 Appeal to the Integrated Administrative Hearing Office (IAHO) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the IAHO reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The IAHO does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The IAHO is not connected with our plan.
- A Hearing Officer from the IAHO will take a careful look at all of the information related to your appeal.
- **If this organization says *Yes*** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If this organization says *No*** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

***At a glance:* How to make a Level 2 Appeal to require that the plan continue your care**

You do not have to do anything. The plan will automatically send your appeal to the Integrated Administrative Hearing Office (IAHO).

The letter you get from the IAHO will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal with the Medicare Appeals Council (MAC). Section 9 of this chapter has more information about additional appeal levels.

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for services, items, and drugs (not Medicare Part D drugs)

If you made a Level 1 Appeal and a Level 2 Appeal as described in Sections 5, 7, or 8, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Integrated Administrative Hearing Office (IAHO) will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is a review by the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800. TTY users call 711.

Section 9.2: Next steps for Medicare Part D drugs

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare Part D drugs as described in Section 6, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the drugs you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800. TTY users call 711.

Section 10: How to file a grievance

What kinds of problems should be grievances?

"Filing a grievance" is another way of saying "making a complaint." The grievance process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the grievance process.

Grievances about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Grievances about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Grievances about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- GuildNet Gold Plus FIDA Plan staff treated you poorly.
- You think you are being pushed out of GuildNet Gold Plus FIDA Plan.

Grievances about physical accessibility

- You cannot physically access the health care services and facilities in a provider's office.

Grievances about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by providers, pharmacists, or other health professionals or by Participant Services or other GuildNet Gold Plus FIDA Plan staff.

Grievances about cleanliness

- You think the clinic, hospital or provider's office is not clean.

***At a glance:* How to make a grievance**

Call Participant Services or send us a letter telling us about your grievance.

➔ If your grievance is about *quality of care*, you have more choices. You can:

1. Make your grievance to the Quality Improvement Organization,
2. Make your grievance to Participant Services and to the Quality Improvement Organization, or
3. Make your grievance to Medicare.

Grievances about language access

- Your provider does not provide you with an interpreter during your appointment.

Grievances about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Grievances about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain services.
- You believe we did not forward your case to the Integrated Administrative Hearing Office or Independent Review Entity on time.

Are there different types of grievances?

You may file an internal grievance or an external grievance. An internal grievance is filed with and reviewed by GuildNet Gold Plus FIDA Plan. An external grievance is filed with and reviewed by an organization that is not affiliated with GuildNet Gold Plus FIDA Plan. If you need help filing an internal and/or external grievance, you can call the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800. TTY users call 711.

Section 10.1: Internal grievances

To file an internal grievance, call Participant Services at 1-800-815-0000 (TTY: 1-800-662-1220). The grievance must be made within 60 calendar days after you had the problem you want to complain about.

- If there is anything else you need to do, Participant Services will tell you.
- You can also write your grievance and send it to us. If you put your grievance in writing, we will respond to your grievance in writing.

Most grievances are answered in 30 calendar days. If possible, we will answer you right away. If you call us with a grievance, 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.

- If you need a response faster because of your health, we will give you an answer within 48 hours after we get all necessary information (but no more than 7 calendar days from the receipt of your grievance).

- If you are filing a grievance because we denied your request for a "fast coverage decision" or a "fast appeal," we will respond to your grievance within 24 hours.
- If you are filing a grievance because we took extra time to make a coverage decision, we will respond to your grievance within 24 hours.

If we do not agree with some or all of your grievance, we will tell you and give you our reasons. We will respond whether we agree with the grievance or not. If you disagree with our decision, you can file an external grievance.

Section 10.2: External grievances

You can tell Medicare about your grievance

You can send your grievance (complaint) to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Your grievance will be sent to the Medicare and Medicaid team overseeing GuildNet Gold Plus FIDA Plan and the FIDA Program.

You can tell the New York State Department of Health about your grievance

To file a grievance with the New York State Department of Health (NYSDOH), call the NYSDOH Helpline at 1-866-712-7197. Your grievance will be sent to the Medicare and Medicaid team overseeing GuildNet Gold Plus FIDA Plan and the FIDA Program.

You can file grievances about disability access or language assistance with the Office of Civil Rights

If you have a grievance about disability access or about language assistance, you can file a grievance with the Office of Civil Rights at the Department of Health and Human Services at

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Voice Phone (800) 368-1019
FAX (212) 264-3039
TDD (800) 537-7697

You may also have rights under the Americans with Disability Act and under NY State ADA Title II: State and Local Government Activities. You can contact the Independent Consumer Advocacy Network (ICAN) for assistance.

You can file grievances about quality of care to the Quality Improvement Organization

When your grievance is about *quality of care*, you also have two choices:

- If you prefer, you can make your grievance about the quality of care directly to the Quality Improvement Organization (*without* making the grievance to us).
- Or you can make your grievance to us *and also* to the Quality Improvement Organization. If you make a grievance to this organization, we will work with them to resolve your grievance.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is 1-866-815-5440.

Chapter 10: Ending your participation in our FIDA Plan

Table of Contents

Introduction

This chapter tells about ways you can end your participation in our FIDA Plan and access your Medicare and Medicaid coverage options after you leave GuildNet Gold Plus FIDA Plan. You will still qualify for both Medicare and Medicaid benefits if you leave GuildNet Gold Plus FIDA Plan.

A. When can you end your participation in our FIDA Plan?

You can end your participation in GuildNet Gold Plus FIDA Plan at any time. Your participation will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 25, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month.

➔ For information on Medicare options when you leave our Plan, see the table on pages 198-199.

➔ For information about your Medicaid services when you leave GuildNet Gold Plus FIDA Plan, see pages 199-200.

These are ways you can get more information about when you can end your participation:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541.
- Call the Health Insurance Information, Counseling and Assistance Program (HIICAP). The phone number for HIICAP is 1-800-701-0501.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any issues you may have with your FIDA Plan. To contact ICAN, call 1-844-614-8800. TTY users call 711.

B. How do you end your participation in our FIDA Plan?

If you decide to end your participation in GuildNet Gold Plus FIDA Plan, call the Enrollment Broker or Medicare and tell them you want to leave our Plan:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541; OR

- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our Plan is in the chart on pages 198-199.

C. How do you join a different FIDA Plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different FIDA Plan.

To enroll in a different FIDA Plan:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541. Tell the Enrollment Broker you want to leave GuildNet Gold Plus FIDA Plan and join a different FIDA Plan. If you are not sure which plan you want to join, the Enrollment Broker can tell you about other plans in your area; OR

- If you know the name of the FIDA Plan you want to join, send the Enrollment Broker an Enrollment Change Form. You can get the form at http://www.nymedicaidchoice.com or by calling the Enrollment Broker at 1-855-600-FIDA if you need them to mail you one. TTY users should call 1-888-329-1541.

Your coverage with our Plan end on the last day of the month that we get your request. Your coverage with the new FIDA Plan you selected will begin on the first day of the next month.

D. If you leave our FIDA Plan and you do not want a different FIDA Plan, how do you get your Medicare and Medicaid services from a single plan?

If you leave our Plan and want to keep getting your Medicare and Medicaid services together from a single plan, you may be able to enroll in the Program of All-Inclusive Care for the Elderly (PACE) or the Medicaid Advantage Plus (MAP) Program.

To enroll in PACE or MAP:

- Call the Enrollment Broker (New York Medicaid Choice) at 1-855-600-FIDA, Monday through Friday from 8:30 am to 8:00 pm and Saturday from 10:00 am to 6:00 pm. TTY users should call 1-888-329-1541. Tell the Enrollment Broker you want to leave GuildNet Gold Plus FIDA Plan and enroll in PACE or MAP. If you are not sure which PACE or MAP Plan you want to join, the Enrollment Broker can tell you about other plans in your area.

E. If you leave our FIDA Plan and you do not want a different FIDA, PACE, or MAP Plan, how do you get your Medicare and Medicaid services?

If you do not want to enroll in a different FIDA, PACE, or MAP Plan after you leave GuildNet Gold Plus FIDA Plan, you will go back to getting your Medicare and Medicaid services separately as described below.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By enrolling in one of these options, you will automatically end your participation in GuildNet Gold Plus FIDA Plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage plan	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from GuildNet Gold Plus FIDA Plan when your new plan's coverage begins.

2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from GuildNet Gold Plus FIDA Plan when your Original Medicare coverage begins.
3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the Health Insurance Information, Counseling and Assistance Program (HIICAP) at 1-800-701-0501. You will automatically be disenrolled from GuildNet Gold Plus FIDA Plan when your Original Medicare coverage begins.

How you will get Medicaid services

If you leave the FIDA Plan, you will still be able to receive your Medicaid services.

- You will have the opportunity to switch to a Medicaid Managed Long-Term Care plan for your long-term services and supports and to receive your Medicaid physical and behavioral health services through Medicaid Fee-for-Service. You can choose to completely stop receiving long-term services and supports. However, it may take extra time to complete a safe discharge process.
  - » If you choose to completely stop receiving long-term services and supports, we must ensure that you will be safe without the receipt of these services. To do this, we will complete a safe discharge process. This might take a few weeks from the date you tell us you want to leave long-term services and supports. During this time, you will be enrolled into the Medicaid Managed Long-Term Care plan operated by the same company as GuildNet Gold Plus FIDA Plan. Your change request on your Medicare coverage will not be delayed and will take effect on the first day of the month after you request the change.
- If you were receiving services through the Nursing Home Transition & Diversion 1915(c) waiver prior to enrolling in a FIDA Plan, you will have the opportunity to re-apply for the Nursing Home Transition & Diversion 1915(c) waiver. You will continue to receive any existing Nursing Home Transition & Diversion services from our Plan or enroll in a Medicaid Managed Long-Term Care plan to receive your Medicaid services until your application for the Nursing Home Transition & Diversion 1915(c) waiver is approved. The Enrollment Broker (New York Medicaid Choice) can help you with your application.
- You will get a new Medicaid Participant ID card, a new Participant Handbook, and a new Provider and Pharmacy Directory.

F. Until your participation ends, you will keep getting your medical services and drugs through our FIDA Plan

If you leave GuildNet Gold Plus FIDA Plan, it may take time before your participation ends and your new Medicare and Medicaid coverage begins. See page 196 for more information. During this time, you will keep getting your services, items, and drugs through GuildNet Gold Plus FIDA Plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your participation ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new coverage begins before you are discharged.

G. Your participation will end in certain situations (even if you haven't asked for it to end)

These are the cases when the FIDA Program rules require that your participation must end:

- If there is a break in your in Medicare Part A and Part B coverage.
- If you no longer qualify for Medicaid.
- If you permanently move out of our service area.
- If you are away from our service area for more than six consecutive months.
  - » If you move or take a long trip, you need to call Participant Services to find out if the place you are moving or traveling to is in the Plan's service area.
- If you go to jail, prison, or a correctional facility.
- If you lie about or withhold information about other insurance you have for health care or prescription drugs.

In any of the above situations, the Enrollment Broker (New York Medicaid Choice) will send you a disenrollment notice and will be available to explain your other coverage options.

In addition, we can request that the FIDA Program remove you from GuildNet Gold Plus FIDA Plan for the following reasons:

- If you intentionally give us incorrect information when you are enrolling in the Plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other Participants of our Plan even after we make and document our efforts to resolve any problems you may have.
- If you knowingly fail to complete and submit any necessary consent or release form allowing our Plan and providers to access health care and service information that is necessary for us to deliver care to you.
- If you let someone else use your ID card to get medical care.
  - » If we end your participation because of this reason, Medicare may have your case investigated by the Inspector General.

In any of the above situations, we will notify you of our concern before we request FIDA Program approval to have you disenrolled from our Plan. We will do this so that you have the opportunity to resolve the problems first. If the problems aren't resolved, we will notify you again once we have submitted the request. If the FIDA Program approves our request, you will receive a disenrollment notice. The Enrollment Broker will be available to explain your other coverage options.

H. We *cannot* ask that you be disenrolled from our FIDA Plan for any reason related to your health

If you feel that we are requesting that you be disenrolled from our Plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. You should also call Medicaid at 1-800-541-2831.

I. You may have the right to request a fair hearing if the FIDA Program ends your participation in our FIDA Plan

If the FIDA Program ends your participation in GuildNet Gold Plus FIDA Plan, the FIDA Program must tell you its reasons in writing. It must also explain how you can request a fair hearing about the decision to end your participation.

J. You have the right to file a grievance with GuildNet Gold Plus FIDA Plan if we ask the FIDA Program to end your participation in our FIDA Plan

If we ask the FIDA Program to end your participation in our plan, we must tell you our reasons in writing. We must also explain how you can file a grievance about our request to end your participation. You can see Chapter 9 for information about how to file a grievance.

➔ **Note:** You can use the grievance process to express your dissatisfaction with our request to end your participation. However, if you want to ask that the decision be changed, you must file a fair hearing as described in Section I just above.

K. Where can you get more information about ending your participation in our FIDA Plan?

If you have questions or would like more information on when we can end your participation, you can call Participant Services at 1-800-815-0000, Monday through Sunday, 8am to 8pm. TTY users call 1-800-662-1220.

The Independent Consumer Advocacy Network (ICAN) can also give you free information and assistance with any issues you may have with your FIDA Plan. To contact ICAN, call 1-844-614-8800. TTY users call 711.

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Participant Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, sex, sexual orientation, gender identity, health, ethnicity, or creed. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about our Plan as a second payer

Sometimes someone else has to pay first for the services, items, and drugs that we provide. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

The Plan has the right and responsibility to collect payment for covered services, items, and drugs when someone else has to pay first.

Our Plan's Right of Subrogation

Subrogation is the process by which our Plan gets back some or all of the costs of your health care from another insurer. Examples of other insurers include:

- Your motor vehicle or homeowner's insurance
- The motor vehicle or homeowner's insurance of an individual who caused your illness or injury
- Workers' Compensation

If an insurer other than our Plan should pay for services, items, or drugs related to an illness or injury, the Plan has the right to ask that insurer to repay us. Unless otherwise required by law, coverage under this policy by the Plan will be secondary when another plan, including another insurance plan, provides you with coverage for FIDA-covered services, items, or drugs.

Our Plan's Right of Reimbursement

If you get money from a lawsuit or settlement for an illness or injury, the Plan has a right to ask you to repay the cost of covered services that we paid for. We cannot make you repay us more than the amount of money you got from the lawsuit or settlement.

Your Responsibilities

As a Participant of our Plan, you agree to:

- Let us know of any events that may affect our Plan's rights of Subrogation or Reimbursement.
- Cooperate with our Plan when we ask for information and assistance with Coordination of Benefits, Subrogation, or Reimbursement.
- Sign documents to help the Plan with its rights to Subrogation and Reimbursement.
- Authorize us to investigate, request and release information which is necessary to carry out Coordination of Benefits, Subrogation, and Reimbursement to the extent allowed by law.

If you are not willing to help us, you may have to pay us back for our costs, including reasonable attorneys' fees, in enforcing our rights under this plan.

D. Participant confidentiality and notice about privacy practices

We will ensure that all information, records, data, and data elements related to you, used by our organization, employees, subcontractors, and business associates, shall be protected from unauthorized disclosure pursuant to 42 CFR Part 431, Subpart F; 45 CFR Part 160; and 45 CFR Part 164, Subparts A and E.

We are required by law to provide you with a Notice that describes how health information about you may be used and disclosed, and how you can get this information. Please review this Notice of Privacy Practices carefully. If you have any questions, call Participant Services at 1-800-815-0000. TTY/TDD users, please call 1-800-662-1220 or visit www.guildnetny.org to see the notice about privacy practices..

E. Notice of action

We must use the Notice of Denial of Medical Coverage form to notify you of a denial, termination, and delay or modification in benefits. If you disagree with our decision, you can file an appeal with our plan. You will not have to pay for any of these proceedings. For more information about appeals, see Chapter 9.

Chapter 12: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, walking, or brushing the teeth.

Aid paid pending: You can continue getting your services or items that are the subject of your appeal while you are waiting for a decision on a Level 1, 2, or 3 Appeal. This continued coverage is called "aid paid pending" or "continuing benefits." All other services and items automatically continue at approved levels during your appeal.

Appeal: A way for you to challenge a coverage decision if you think it is wrong. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person when only GuildNet Gold Plus FIDA Plan should be billed. We do not allow providers to "balance bill" you. Because our Plan pays the entire cost for your services, you should not get any bills from providers. Call Participant Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same active ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Manager: One main person who works with you, with the FIDA Plan, with your care providers, and with your Interdisciplinary Team (IDT) to make sure you get the care you need.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid. Chapter 2 explains how to contact CMS.

Comprehensive assessment: A review of your medical history, your needs and preferences, and your current conditions. It is used by you and your Interdisciplinary Team (IDT) to develop your Person-Centered Service Plan (PCSP). The term refers both to the initial comprehensive assessment you will have when you first join GuildNet Gold Plus FIDA Plan and the subsequent comprehensive re-assessments you will have at least every six months but more frequently if necessary due to changes in your needs. The comprehensive assessment and reassessments will be completed by a Registered Nurse in your home, which may include the hospital, nursing facility, or any other place you live at the time the assessment occurs.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Continuing benefits: See "aid paid pending."

Coverage decision: A decision made by your IDT, GuildNet Gold Plus FIDA Plan, or another authorized provider about whether GuildNet Gold Plus FIDA Plan will cover a service for you. This includes decisions about covered services, items, and drugs. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and other drugs covered by our Plan.

Covered services and items: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our Plan. Covered services and items are individually listed in Chapter 4.

Disenrollment: The process of ending your membership in GuildNet Gold Plus FIDA Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tier: A group of drugs of the same type (for example, brand name, generic, or over-the-counter drugs). Every drug on the List of Covered Drugs is in one of four tiers.

Emergency: A medical emergency is when you, or any other person with average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. The plan covers emergency care from out-of-network providers.

Enrollment Broker: The independent entity (New York Medicaid Choice) that handles FIDA Plan enrollments and disenrollments for the State of New York.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Explanation of Benefits (EOB): A summary of the drugs you received during a certain month. It also shows the total payments made by GuildNet Gold Plus FIDA Plan and Medicare for you since January 1.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in New York State court and show that a decision we made about your Medicaid or FIDA Program eligibility is wrong.

Fully Integrated Duals Advantage (FIDA) Plan: A managed care organization under contract with Medicare and Medicaid to provide eligible individuals with all services available through both programs as well as new services. The plan is made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. They all work together to provide the care you need.

Fully Integrated Duals Advantage (FIDA) Program: A demonstration program jointly run by New York State and the federal government to provide better health care for people who have both Medicare and Medicaid. Under this demonstration, the State and federal government are testing new ways to improve how you receive your Medicare and Medicaid health care services.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Health Insurance Information, Counseling and Assistance Program (HIICAP): HIICAP is the State Health Insurance Assistance Program for New York. HIICAP gives free health insurance counseling to people with Medicare. HIICAP is not connected with any insurance company, managed care plan, or FIDA Plan.

Hospice: A program of care and support for people who are terminally ill to help them live comfortably. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. A Participant who has six months or less to live has the right to elect hospice. We must give you a list of hospice providers in your geographic area.

Independent Consumer Advocacy Network (ICAN): An office that helps you if you are having problems with GuildNet Gold Plus FIDA Plan. ICAN's services are free. See Chapter 2 for information about how to contact ICAN.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated Administrative Hearing: A meeting before the Integrated Administrative Hearing Office during which you can explain why you think our Plan or your Interdisciplinary Team (IDT) made the wrong decision.

Integrated Administrative Hearing Office: A unit within the New York State Office of Temporary and Disability Assistance that conducts many of the Level 2 Appeals as described in Chapter 9.

Interdisciplinary Team (IDT): Your IDT will include your Primary Care Provider (PCP), Care Manager, and other health professionals who are there to help you get the care you need. Your IDT will also help you make a Person-Centered Service Plan (PCSP) and coverage decisions.

List of Covered Drugs (Drug List): A list of prescription drugs covered by GuildNet Gold Plus FIDA Plan. The Plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS are sometimes also referred to as long-term care, long-term supports and services, or home and community-based services.

Managed Long-Term Care Program (MLTCP): The Managed Long-Term Care Program is the Medicaid program through which eligible individuals can get community or facility-based **long-term services and supports (**LTSS) through a managed care plan under contract to provide these and other Medicaid services.

Medicaid (or Medical Assistance): A program run by the federal government and the State that helps people with limited incomes and resources pay for health care, long-term services and supports, and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2 for information about how to contact Medicaid in your state.

Medicaid Advantage Plus (MAP) Program: A Medicare and Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program. Please see Chapter 10 for more information about selecting the MAP.

Medically necessary: Those services and items necessary to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap. Our Plan will provide coverage in accordance with the more favorable of the current Medicare and New York State Department of Health (NYSDOH) coverage rules, as outlined in NYSDOH and federal rules and coverage guidelines**.**

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease

(generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan.

Medicare Appeals Council: The entity that conducts Level 3 Appeals, as described in Chapter 9.

Medicare-covered services and items: Services and items covered by Medicare Part A and Part B. All Medicare health plans, including GuildNet Gold Plus FIDA Plan, must cover all of the services and items that are covered by Medicare Part A and Part B.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. GuildNet Gold Plus FIDA Plan includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our Plan Participants. We call them "network pharmacies" because they have agreed to work with us. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the State to provide health care services. We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our Participants an extra amount. While you are a Participant of our Plan, you must use network providers to get covered services and items, unless under certain conditions such as in cases of an emergency or urgently needed care. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Organization determination: GuildNet Gold Plus FIDA Plan has made an organization determination when it, or one of its providers, makes a decision about whether services and items are covered or how much you have to pay for covered services and items. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the federal government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers in amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in GuildNet Gold Plus FIDA Plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with GuildNet Gold Plus FIDA Plan to coordinate or provide covered drugs to Participants of GuildNet Gold Plus FIDA Plan. Most drugs you get from out-of-network pharmacies are not covered by GuildNet Gold Plus FIDA Plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by GuildNet Gold Plus FIDA Plan and is not under contract to provide covered services and items to Participants of GuildNet Gold Plus FIDA Plan. Chapter 3 explains out-of-network providers or facilities. You may see providers who are not in our network to access services that you used to get through your Original Medicare coverage. You do not need the Plan's permission to access Medicare services from providers outside of our network. **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare. We cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Partial/MLTC Plan: A Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program for Medicaid long-term services and supports (LTSS).

Participant (Participant of our plan, or plan Participants): A person with Medicare and Medicaid who qualifies to get covered services and items through the FIDA Program, who has enrolled in GuildNet Gold Plus FIDA Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the State.

***Participant Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a Participant of our Plan.

Participant Services: A department within our Plan responsible for answering your questions about your participation, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Participant Services.

Person-Centered Service Plan (PCSP): A plan for what services and items you will get, how you will get them, and your goals of care. Your PCSP is developed by your Interdisciplinary Team (IDT) with your input.

Point-Of-Service (POS) Plan – In some plans, you may be able to go out-of-network for certain services, usually for a higher cost. This is called an HMO with a point-of-service (POS) option.

Primary Care Provider (PCP): Your main doctor or other provider who is responsible for providing many of your preventive and primary care services and items. Your PCP will be a part of your Interdisciplinary Team (IDT). Your PCP will participate in developing your Person-Centered Service Plan (PCSP), making coverage determinations about services and items requested by or for you, and approving authorizations for services and items that will be part of your PCSP. Your PCP may be a primary care physician, a nurse practitioner, or a physician assistant. For more information, see Chapter 3.

Prior authorization: Approval needed before you can get certain covered services, items, or drugs. Some services, items, and drugs are covered only if GuildNet Gold Plus FIDA Plan, your IDT, or another specific provider authorizes them for you. Covered services and items that need prior authorization are marked in the Covered Items and Services Chart in Chapter 4. Some drugs are covered only if you get prior authorization from GuildNet Gold Plus FIDA Plan or the IDT. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Program of All-Inclusive Care for the Elderly (PACE): A Medicare and Medicaid managed care plan program that is available to eligible individuals as an alternative to the FIDA Program. Please see Chapter 10 for more information about selecting PACE.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to Participants. See Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription or how many refills you can get.

Self-directed care: A program that gives you the flexibility to choose and manage your caregivers. You (or your designee) are responsible for recruiting, hiring, training, supervising, and terminating caregivers. For more information, see Chapters 3 and 4.

Service area: A geographic area where a health plan accepts Participants. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. GuildNet Gold Plus FIDA Plan may request FIDA Program permission to drop you from the FIDA Plan if you move out of the FIDA Plan's service area. For more information about the FIDA Plan's service area, see Chapter 1.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The New York State Medicaid Agency is the New York State Department of Health (NYSDOH), Office of Health Insurance Programs (OHIP).

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

GuildNet

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