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YOUR MEMBER HANDBOOK HAS BEEN CHANGED |

ADDENDUM TO THE NEW YORK STATE < MEDICAID MANAGED CARE/HEALTH AND RECOVERY PLAN> MEMBER HANDBOOK FOR THE INTEGRATED BENEFITS FOR DUALLY ELIGIBLE ENROLLEES (IB-DUAL) PROGRAM

Introduction

This member handbook addendum provides information for members of the Integrated Benefits for Dually Eligible Enrollees (IB-Dual) Program. The IB-Dual program allows Medicare-eligible members to be enrolled in <Medicaid Managed Care/Health and Recovery Plan (HARP)>. Members will get their Medicare and Medicaid benefits through MetroPlusHealth Medicaid Managed Care Plan or MetroPlusHealth Enhanced (HARP), and MetroPlus Advantage Plan (HMO D-SNP).

How to Use This Handbook Addendum

This addendum will tell you how your new integrated health care program works and how you can get the most from MetroPlusHealth. It provides you with information that applies to an IB-Dual member (i.e., a member who has both Medicare and Medicaid coverage with the same health plan).

This includes information about enrollment, disenrollment, access to services, and how to file a complaint or appeal that may be different than what is included in your <MetroPlusHealth Medicaid Managed Care Plan/MetroPlusHealth Enhanced (HARP)> member handbook.

When you have a question, check your handbook or call MetroPlusHealth Member Services.

Enrollment

To be a member of the IB-Dual Program offered by MetroPlusHealth, you must:

- Have both Medicare Part A and Medicare Part B and be enrolled in MetroPlusHealth Medicare Advantage Dual Special Needs Plan (D-SNP) Part C,

- Live in the plan's service area, which includes the following counties: New York (Manhattan), Bronx, Queens, Kings (Brooklyn), and Richmond (Staten Island),
- Be a United States citizen or be lawfully present in the United States,
- Be enrolled in MetroPlusHealth Medicaid Managed Care or MetroPlusHealth Enhanced Health and Recovery Plan, and
- Not be in receipt of community based long term care services (CBLTSS) for more than 120 days

Your Health Plan Identification (ID) Card

After you enroll, you will be sent a welcome letter. Your new MetroPlusHealth IB-Dual ID card should arrive within 14 days after your enrollment date. Your card has your primary care provider's (PCP's) name and phone number on it. It will also have your Member ID number. If anything is wrong on your MetroPlusHealth IB-Dual ID card, call us right away. Your IB-Dual ID card does not show that you have Medicaid or that MetroPlusHealth is a special type of health plan. For services covered only by MetroPlusHealth Medicaid Managed Care or MetroPlusHealth Enhanced (HARP), you should continue to use your MetroPlusHealth Medicaid Managed Care or MetroPlusHealth Enhanced (HARP) member ID card.

Always carry your IB-Dual ID card and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need this card to get services that MetroPlusHealth does not cover.

Disenrollment

You may disenroll from the IB-Dual program at any time. If you voluntarily disenroll from either the Medicare or Medicaid coverage with us, your coverage under this program will end.

You may be involuntarily disenrolled from your IB-Dual program if you:

- permanently move out of our service area for the IB-Dual program,
- lose your Medicaid coverage and don't regain it within 90 days (see below under "Loss of Medicaid Eligibility" for more information),
- are in receipt of long term care services for more than 120 days (if MetroPlusHealth finds that you require long term care services for more than 120 days, you will be offered the option to enroll in a Managed Long Term Care (MLTC) plan, or
- become eligible for a long term nursing home stay.

Medicare Coverage

If you disenroll from the MetroPlusHealth IB-Dual program, you can enroll in a Medicare Advantage plan. If you do not enroll in a Medicare Advantage plan, the federal

government will enroll you in Original Medicare for your medical care and in a Prescription Drug Plan (PDP) for your prescription drug coverage.

Medicaid Coverage

If you disenroll from the MetroPlusHealth IB-Dual program, New York Medicaid Choice will enroll you in regular Medicaid.

Note: If you disenroll from the IB-Dual program in error, please contact the plan as soon as possible.

Loss of Medicaid Eligibility

If you lose Medicaid eligibility, your coverage in the IB-Dual program will end. However, you will have a 90-day grace period when your Medicare coverage will continue with the MetroPlusHealth D-SNP. If you regain Medicaid eligibility during the 90-day grace period, your coverage in the IB-Dual program will be reinstated. If you do not regain Medicaid eligibility during the 90-day grace period, you will be responsible for any copayments, coinsurance, premiums, and/or deductibles for which Medicaid would otherwise cover had you not lost your Medicaid eligibility.

Coordinating your Benefits

MetroPlusHealth will coordinate both your Medicare and Medicaid benefits through the IB-Dual program. Your cost-sharing for Medicare-covered services will be $0 because Medicaid will cover your Medicare cost-sharing amounts.

Some services not covered by MetroPlusHealth are available through regular Medicaid or Original Medicare (for example, non-emergency transportation and hospice services). Additionally, the Medicaid Pharmacy Program (NYRx) will cover select over the counter (OTC) drugs, prescription vitamins, and cough suppressants that are not covered by Medicare Part D. You will continue to have access to regular Medicaid services during your enrollment in the IB-Dual plan.

Service Authorization, Appeals, and Complaints

Service Authorization

For services that are covered by Medicare or by both Medicare and Medicaid, MetroPlusHealth will make decisions about your care as described in Chapter 9 of your Medicare Advantage D-SNP Evidence of Coverage (EOC). These are also known as Coverage Decisions.

For services covered only by Medicaid, MetroPlusHealth will make decisions about your care following our Service Authorization rules described in Part II of your member handbook.

Appeals

Because you have both Medicare and Medicaid, the way you make appeals about your services will depend on whether the services are covered by Medicare or Medicaid.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file an appeal (also known as a Level 1 appeal) or complaint on a decision MetroPlusHealth makes about a service that is covered only by Medicare (such as chiropractic services) using the Medicare process.

Part II of your <MetroPlusHealth Medicaid Managed Care Plan/MetroPlusHealth Enhanced (HARP)> member handbook tells you how to file an appeal (also known as a Plan Appeal) on a decision MetroPlusHealth makes about a service that is covered only by Medicaid (such as personal care services) using the Medicaid process.

For services covered by **both** Medicare and Medicaid, you can file an appeal using the Medicare process, the Medicaid process, or both processes.

- If you follow the Medicare process to appeal, you cannot use your Medicaid appeal rights, which includes the right to a state Fair Hearing and may also include the right to an External Appeal.

- If you follow the Medicaid process to appeal, you will still have 60 days from the day of MetroPlusHealth's notice of action to use your Medicare appeal rights instead.

Aid to continue while appealing a decision about your care

If MetroPlusHealth reduces, suspends, or stops a service, and the service is covered by Medicaid, you may be able to continue the service while you wait for an appeal determination.

You must ask for a Medicaid Plan Appeal:

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

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

If you are unhappy with your appeal decision, you can appeal again.

- If the appeal is for a service covered only by Medicare, MetroPlusHealth will automatically forward your case to the Medicare Independent Review Entity (IRE). See Chapter 9 of your Medicare Advantage D-SNP EOC about Level 2 appeals.
- If the appeal is for a service covered only by Medicaid, see Part II of the <MetroPlusHealth Medicaid Managed Care Plan/MetroPlusHealth Enhanced

(HARP)> member handbook about how to file a Fair Hearing. In some cases, you may also be able to file an External Appeal.
    - If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

- If the appeal is for a service covered by **both** Medicare and Medicaid, MetroPlusHealth will forward your case to the IRE. You may also file a Fair Hearing. In some cases, you may also be able to file an External Appeal. See Part II of the <MetroPlusHealth Medicaid Managed Care Plan/MetroPlusHealth Enhanced (HARP)> member handbook on how to file a Fair Hearing and External Appeal.
    - If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

Aid to continue while waiting for a Medicaid Fair Hearing decision

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

You must ask for a Fair Hearing:

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

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

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

Complaints

Because you have both Medicare and Medicaid, the way you make a complaint about your services will depend on whether the benefit is covered by Medicare or Medicaid.

Chapter 9 of your Medicare Advantage D-SNP EOC tells you how to file a complaint about Medicare benefits.

Part II of your <MetroPlusHealth Medicaid Managed Care Plan/MetroPlusHealth Enhanced (HARP)> member handbook tells you how to file a complaint about Medicaid benefits.

For complaints about your Medicare and Medicaid benefits, you can file a complaint using the Medicare process, the Medicaid process, or both.

- If you follow the Medicaid process to complain, and you disagree with the decision MetroPlusHealth made about your complaint, you can file a complaint appeal with MetroPlusHealth.