

MEMBER HANDBOOK

METROPLUS
ULTRACARE
(HMO D-SNP)



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WELCOME TO METROPLUS HEALTH PLAN (HMO D-SNP) MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to MetroPlus Health Plan (HMO D-SNP) Medicaid Advantage Plus (MAP) Program. The MAP Program is designed for people who have Medicare and Medicaid and who need health services and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits MetroPlus Health Plan (HMO D-SNP) covers since you are enrolled in the MetroPlus Health Plan (HMO D-SNP) MAP Program. It also tells you how to request a service, file a complaint, or disenroll from MetroPlus Health Plan (HMO D-SNP) MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the MetroPlus Health Plan (HMO D-SNP) Medicare *Evidence of Coverage*. Keep this handbook with the MetroPlus Health Plan (HMO D-SNP) Medicare *Evidence of Coverage*. You need both to learn what services are covered, and how to get services.

Section I - HELP FROM METROPLUS HEALTH PLAN (HMO D-SNP) MEMBER SERVICES

You can call us at the MetroPlus UltraCare (HMO D-SNP) Member Services numbers below.

There is someone to help you at Member Services:
Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm.
Call 866.986.0356 (TTY: 711).

If you need help at other times, call our
after-hours answering service at 800.442.2560.

More Resources

- This document is available for free in Spanish and Chinese.
- Call Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. This call is free.
- We also provide free language services to people whose first language is not English, such as qualified interpreters, and information written in other languages. Call New York Medicaid Choice at 800.505.5678 if you need interpreter services or program information in Braille or on CD. TTY users: 888.329.1541. Counselors are available to help explain or answer questions relating to enrollment.
- ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 866.986.0356 (TTY: 711). 请注意：您可以免费获得语言协助服务和其他辅助服务。请电 866.986.0356 (TTY: 711).
- We can also give you information in Braille, large print, or other alternate formats upon request.

- MetroPlus Health Plan, Inc. is not affiliated with, endorsed by, or otherwise related to the federal government, CMS, HHS, and/or Medicare. MetroPlus Health Plan, Inc. complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Section II - ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

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

- 1) Are age 18 or older,
- 2) Reside in the Plan's service area which is the Bronx, Brooklyn, Manhattan, Queens, and Staten Island,
- 3) Have Medicaid,
- 4) Have evidence of Medicare Part A & B coverage,
- 5) Must enroll in MetroPlus Health Plan (HMO D-SNP) Medicare Advantage Dual Special Needs Plan
- 6) Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, or you are permanently placed in a nursing home,
- 7) Need at least one CBLTSS for more than 120 days and the following:
 - individuals with a diagnosis by a physician of Dementia or Alzheimer's and need help with at least supervision with more than one activity of daily living (ADL); or
 - individuals who are assessed as needing at least limited assistance with physical maneuvering with more than two ADLs.

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

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

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

You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave the MetroPlus Health Plan (HMO D-SNP) MAP program.

The coverage explained in this handbook becomes effective on the effective date of your enrollment in the MetroPlus Health Plan (HMO D-SNP) MAP program. Enrollment in the MAP program is voluntary.

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

The NYIAP will conduct an initial assessment for individuals who have expressed an interest in enrolling in a Managed Long Term Care plan. The initial assessment process includes completing the:

- ***Community Health Assessment (CHA)***: The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a MLTC plan.
- ***Clinical appointment and Practitioner Order (PO)***: The PO documents your clinical appointment and indicates that you:
 - have a need for help with daily activities, **and**
 - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

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

Annually, you as a MLTC enrollee will then be reassessed by MetroPlus Health Plan (HMO D-SNP), to ensure your needs still meet the MLTC Program Eligibility requirements.

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

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

How Do I Enroll?

Enrolling in MetroPlus Health Plan (HMO D-SNP) is easy. Our staff can help you each step of the way, as outlined below.

You or your family/caregiver, or another person who helps you get medical services, may contact MetroPlus Health Plan (HMO D-SNP) by phone. Our staff is available Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm, to talk to you about the Medicare and Medicaid/MAP program

and get the process started. To let us know that you are interested in learning more about the program, just call 866.986.0356 (TTY: 711).

A MetroPlus Health Plan (HMO D-SNP) representative will talk to you and explain the program and benefits. He/she will determine that you are Medicare eligible (have Part A & B); meet the Plan's age requirements; reside in our service area; and, have or are interested in Medicaid benefits and/or need long-term care services and supports for more than 120 consecutive days.

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and full Medicaid benefits (must be enrolled in our Medicare Advantage product).

In addition, you must:

- 1) Be 18 years of age or older
- 2) Reside in our plan's service area which is the Bronx, Brooklyn, Manhattan, Queens, and Staten Island
- 3) Be eligible for nursing home level of care (as of the time of enrollment) using the Uniform Assessment System (UAS) or other tool designated by SDOH
- 4) Be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety, based upon criteria provided by SDOH; and
- 5) Need at least one (1) of the following community-based long-term care services for more than 120 days from the effective date of enrollment:
 - Nursing services in the home
 - Therapies in the home
 - Home health aide services
 - Personal care services in the home
 - Adult day health care
 - Private Duty Nursing, or
 - Consumer Directed Personal Assistance Services

Please note: If you lose your eligibility but can reasonably be expected to regain eligibility within three (3) month(s), then you are still eligible for membership in our plan.

If you are interested in enrolling, we will connect you to a licensed sales representative who will discuss the MetroPlus Health Plan (HMO D-SNP) benefits with you over the telephone, or will schedule an in-home appointment with you. During the appointment, the sales representative will provide you with detailed information about the MetroPlus Health Plan (HMO D-SNP) benefit package, the provider network, Part D pharmacy benefits, and address any questions you may have. When you agree to enroll, the sales representative will assist you with completing the Medicare enrollment application.

If you are new to long-term care services and supports and interested in enrolling in MetroPlus

UltraCare (HMO D-SNP), a sales representative will refer you to the New York Independent Assessor Program (NYIAP) at 855.222.8350, TTY: 888.329.1541. You may call Monday to Friday, from 8:30am to 8:00pm, or Saturday from 10:00am to 6:00pm. Counselors speak all languages. The phone call and help are free. Or, you can visit nymedicaidchoice.com to complete an evaluation to find out if you are eligible to enroll. NYIAP is the entity that contracts with the Department of Health to provide initial evaluations to determine if an applicant is eligible for Community Based Long-Term Care for a continuous period of more than 120 days. NYIAP will be responsible for providing conflict-free determinations by completing the Uniform Assessment System (UAS) for applicants in need of care. NYIAP evaluations are conducted in your home -- including hospital or nursing home -- by a registered nurse. Once the nurse decides you meet basic eligibility requirements, he or she will tell you about your choices concerning long-term care plans you may join.

If you are transferring from another Managed Long-Term Care (MLTC) Plan, a conflict-free evaluation will not be needed. A conflict-free evaluation is needed only if you are new to long-term care services and enrolling for the first time, or if you have not been enrolled in a plan for 45 days, or if your NYIAP evaluation has expired.

Once New York Medicaid Choice (NYMC) and MetroPlus Health Plan (HMO D-SNP) have determined that you are eligible to enroll, your Medicare application will be submitted to CMS. If the Centers for Medicare & Medicaid Services (CMS) confirms your enrollment into MetroPlus UltraCare (HMO D-SNP), the application and corresponding MAP enrollment agreement will be submitted to NYMC. All enrollment applications must be signed no later than the 15th of the month in order for the application to be reviewed and submitted to NYMC by noon on the 20th of the month, to ensure an effective date of the first day of the following month. If your enrollment application is received after the 20th day of the month, the enrollment will take effect the first day of the second month. The effective date of enrollment will be given to you at the time of enrollment. If the effective date changes, MetroPlus UltraCare (HMO D-SNP) will tell you the revised effective date. MetroPlus UltraCare (HMO D-SNP) members will receive a confirmation of enrollment letter which will indicate your effective date of enrollment.

You will receive your MetroPlus Health Plan (HMO D-SNP) member identification card within 14 calendar days of your enrollment effective date after your application is verified and approved by CMS. If we receive and process your enrollment request after the 20th day of the month, you may not receive your ID card before your effective date. You can use your confirmation of enrollment letter as proof of coverage if you have a doctor's appointment or need prescription drugs, and do not have your ID card. You can also call MetroPlus UltraCare (HMO D-SNP)'s Member Services Help Line at 866.986.0356, TTY: 711, and we will verify your eligibility with your provider.

If CMS rejects the enrollment request, after the enrollment has been submitted to NYMC, MetroPlus UltraCare (HMO D-SNP) will notify NYMC within five (5) days of receiving the rejection and you will receive a denial of enrollment letter.

Canceling and/or Withdrawing an Application

If you decide you do not want to join MetroPlus UltraCare (HMO D-SNP), you can withdraw your enrollment request prior to the effective date. In that case, we must receive your verbal or written request by the 20th of the month preceding the effective date. MetroPlus UltraCare (HMO D-SNP) will notify NYMC of your withdrawal and we will mail you a confirmation of cancellation notice.

If you need long-term care services, you may need to contact New York Medicaid Choice at 888.401.6582 or TTY: 888.329.1541.

Service Authorization and Actions

Authorization Requests are requests by a member, or a provider on the member's behalf, for the provision of a service or for a referral to a noncovered service. Qualified clinical personnel will determine if a service is medically necessary and appropriate based on a comprehensive assessment of your current condition. The service authorization process begins with your initial plan of care when you are enrolled.

MetroPlus UltraCare (HMO D-SNP) will act to ensure that service authorizations for all members are carried out in accordance with all applicable Federal and State regulations and all decision timeframes are followed. Every MetroPlus UltraCare (HMO D-SNP) member and member designee has the right to request services. MetroPlus UltraCare (HMO D-SNP) Member Services is available to help you understand the proper timeline for receiving a response to a request and timeframes for processing the request.

Plan Member (ID) Card

You will receive your MetroPlus Health Plan (HMO D-SNP) identification (ID) card within fourteen (14) days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your ID card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact MetroPlus UltraCare (HMO D-SNP)'s Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560.

Behavioral Health Appointment Standards

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

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

If you are unable to schedule a behavioral health appointment within the appointment wait times listed above, you, or your designee, may submit an access complaint to MetroPlus UltraCare (HMO D-SNP) by calling MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm (after-hours answering service: 800.442.2560). Or, you may write us at MetroPlus Health Plan, 50 Water Street, 7th fl., New York, NY 10004, to resolve this issue.

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

Behavioral Health Access Complaint

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

Section III - SERVICES COVERED BY METROPLUS HEALTH PLAN (HMO D-SNP) MAP PROGRAM

Deductibles and Copayments on Medicare Covered Services

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

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

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a Care Manager who is a health care professional, usually a nurse or a social worker. Your Care Manager will work with you and your doctor to decide the services you need and develop a care plan. Your Care Manager will also arrange appointments for any services you need and arrange for transportation to those services.

Additional Covered Services

Because you have Medicaid and qualify for the MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in the MetroPlus UltraCare (HMO D-SNP) network. If you cannot find a provider in our Plan, we will get you the care you need from a provider outside the network. Before you can see the out-of-network specialist, your PCP must

ask for a Prior Authorization. To get the Prior Authorization, your PCP must give us some information. Once we get all the information we need, we will decide within 14 calendar days from the date of your request, if you can see the out-of-network specialist.

The following services are covered by MetroPlus UltraCare (HMO D-SNP):

Service(s)	What Do I Get?	Coverage Rules
Adult Day Health Care	<p>Adult Day Health Care provides care and services in a residential health care facility or approved extension site. Adult Day Health Care centers are under the medical direction of a physician and are set up for those who are functionally impaired but who are not homebound. Adult Day Health Care includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy and dental, pharmaceutical, and other ancillary services, as well as leisure-time activities that are a planned program of diverse meaningful activities.</p>	<p>To be eligible, you must require certain preventive, diagnostic, therapeutic, and rehabilitative or palliative items or services. You must get Adult Day Health Care from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the Adult Day Health Care In-Network provider you select. MetroPlus UltraCare (HMO D-SNP) will assist your In-Network Adult Day Health Care Provider with obtaining doctor’s orders, if needed.</p>
Audiology (hearing services)	<p>Medicaid-covered hearing services and products 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; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts.</p>	<p>These services may also be covered by Medicare. You must get audiology and hearing services from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan.</p>

Service(s)	What Do I Get?	Coverage Rules
Consumer Directed Personal Assistance Services (CDPAS)	An enrollee in need of personal care services, home health aide services, or skilled nursing tasks may receive such services by a consumer-directed personal assistant under the instruction, supervision, and direction of the enrollee or the enrollee's designated representative.	You must coordinate your CDPAS with a Fiscal Intermediary that works with MetroPlus UltraCare (HMO D-SNP). You must also obtain Prior Authorization from the Plan.
Dental	Services include medically necessary preventive, prophylactic, and other dental care, services, supplies, routine exams, prophylaxis (i.e. fluoride treatment), oral surgery, and dental prosthetic and orthotic appliances required to alleviate a serious health condition.	You must get social and environmental supports from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must get a Prior Authorization from the Plan.
Durable Medical Equipment (DME)	Durable medical equipment is made up of devices and equipment, other than prosthetic or orthotic appliances and devices, which have been ordered by a practitioner in the treatment of a specific medical condition and which have the following characteristics: can withstand repeated use for a protracted period; are primarily and customarily used for medical purposes; are generally not useful in the absence of an illness or injury; and, are not usually fitted, designed, or fashioned for an individual's use. Where equipment is intended for use by only one patient, it may be either custom-made or customized.	These items may be covered by Medicare. You must get DME from a MetroPlus UltraCare (HMO D-SNP) provider and obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the in-network DME provider. MetroPlus UltraCare (HMO D-SNP) will assist your DME provider in obtaining doctor's orders, if needed.

Service(s)	What Do I Get?	Coverage Rules
<p>Emergency Transportation (Ambulance service, Nonemergency Transportation)</p>	<p>Covered ambulance services, whether for an emergency or nonemergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health, or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.</p> <p>Nonemergency Transportation is transport by ambulance, ambulette, taxi, or livery service, or public transportation at the appropriate level for the member's condition to obtain necessary medical care and services reimbursed under the Medicaid or the Medicare programs.</p>	<p>These services may also be covered by Medicare. Prior authorization is required.</p> <p>You must get Nonemergency Transportation from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan.</p> <p>Please call MetroPlus UltraCare (HMO D-SNP) Member Services at least two days in advance.</p> <p>Routine/Nonemergency Transportation will be provided through an approved vendor. Prior authorization is required.</p>
<p>Home Delivered Meals and/or meals in a group setting such as a day care</p>	<p>Home-delivered and meals in a group setting are meals provided at home or in congregate settings such as senior centers to individuals unable to prepare meals or have them prepared.</p>	<p>You must get these meals from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan.</p>

Service(s)	What Do I Get?	Coverage Rules
Home Health Care	<p>Covered services include, but are not limited to: Part-time or intermittent skilled nursing and home health aide services. (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week,)</p> <p>Physical therapy, occupational therapy, and speech therapy; medical and social services; medical equipment and supplies.</p> <p>As a dual-eligible member, you are entitled to additional Medicaid-covered home health services not covered by Medicare, such as a physical therapist, to supervise a maintenance program for patients who have reached their maximum restorative potential or a nurse to pre-fill syringes for disabled individuals with diabetes and/or home health aide services as required by an approved plan of care.</p>	<p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>You must obtain prior authorization from the Plan.</p>
Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit	<p>You are covered for unlimited inpatient mental health days, as medically necessary, beyond the 190-day Lifetime Medicare Limit.</p>	<p>You must use an in-network Provider/Facility and obtain prior authorization from the Plan.</p>
Medical Social Services	<p>Medical Social Services include assessing the need for, arranging for, and providing aid for social problems related to the maintenance of a patient in the home where such</p>	<p>You must get Medical Social Services from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan.</p>

Service(s)	What Do I Get?	Coverage Rules
	services are performed by a qualified social worker and provided within a plan of care.	
Medical Supplies	Medical/surgical supplies are items for medical use other than drugs, prosthetic or orthotic appliances, and devices and durable medical equipment or orthopedic footwear that treat a specific medical condition, which are usually consumable, nonreusable, disposable, for a specific purpose and generally have no salvageable value.	You must get medical surgical supplies, and enteral and parenteral feeding supplies, nutrition, and medical/surgical supplies from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the provider providing care. MetroPlus Health Plan (HMO D-SNP) will assist your provider in obtaining doctor's orders, if needed.
Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)	<p>Nursing Home Care is covered for individuals who are considered to be permanently placed in a nursing home, provided you are eligible for institutional Medicaid coverage.</p> <p>Nursing Home Care is care provided to members by a licensed facility.</p>	These services may also be covered by Medicare. Your doctor will need to go to the nursing home. MetroPlus UltraCare (HMO D-SNP) will assist your provider in obtaining doctor's orders if needed. Permanent placement may be covered only if you are eligible for institutional Medicaid. You must use an in-network provider/facility and obtain prior authorization from the Plan.
Nutrition	Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:	These items may be covered by Medicare. You must get services from an in-network MetroPlus UltraCare (HMO D-SNP) provider. You must obtain prior authorization from the Plan. Your doctor will

Service(s)	What Do I Get?	Coverage Rules
	<p>tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.</p> <p>Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition.</p> <p>Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein, or which contain modified protein.</p> <p>Nutrition services include the assessment of nutritional needs and food patterns, or the planning for the provision of foods and drink appropriate for the individual's physical and medical needs and environmental conditions, or the provision of nutrition education and counseling to meet normal and therapeutic needs.</p>	<p>need to provide signed written orders to the provider. MetroPlus UltraCare (HMO D-SNP) will assist your provider in obtaining doctor's orders if needed.</p>
<p>Optometry (vision services)</p>	<p>Medicaid-covered vision services include services of optometrists, ophthalmologists, and ophthalmic dispensers including eyeglasses, medically necessary contact</p>	<p>These services may also be covered by Medicare. You must get vision services from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must obtain prior authorization from the</p>

Service(s)	What Do I Get?	Coverage Rules
	<p>lenses, and polycarbonate lenses, artificial eyes (stock or custom-made), low-vision aids, and low-vision services.</p> <p>Coverage also includes the repair or replacement of parts.</p> <p>Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged, or destroyed.</p>	<p>Plan.</p>
Outpatient Rehabilitation	<p>Physical therapy is rehabilitation services provided by a licensed and registered physical therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Occupational therapy is rehabilitation services provided by a licensed and registered occupational therapist for the purpose of maximum reduction of physical or mental disability and restoration of the member to his or her best functional level. Speech-language therapy is rehabilitation services for the purpose of maximum reduction of</p>	<p>Rehabilitative therapies may be covered by Medicare. You must get services from an in-network MetroPlus UltraCare (HMO D-SNP) provider. You must obtain prior authorization from the Plan for more than 10 visits in a year. Your doctor will need to provide signed written orders to the rehabilitation therapist. MetroPlus UltraCare (HMO D-SNP) will assist your rehabilitative provider in obtaining doctor's orders, if needed.</p>

Service(s)	What Do I Get?	Coverage Rules
	physical or mental disability and restoration of the member to his or her best functional level.	
<p>Personal Care (such as assistance with bathing, eating, dressing, toileting, and walking)</p>	<p>Personal care is some or total assistance with activities such as personal hygiene, toileting, housekeeping, dressing, feeding, and nutritional and environmental support function tasks.</p>	<p>You must get personal care services from the MetroPlus UltraCare (D-SNP) provider network, and you must obtain prior authorization from the Plan. Your doctor will need to provide signed written orders to the agency providing Personal Care. MetroPlus UltraCare (HMO D-SNP) will assist your Personal Care provider in obtaining doctor's orders, if needed.</p> <p><i>Consumer Directed Personal Assistance Program:</i></p> <p>Statewide Fiscal Intermediary As of April 1, 2025, members must contact Public Partnerships Ltd. (PPL) to register: PPL Support Center 833.247.5346 or TTY: 833. 204.9042 Website: pplfirst.com/cdpap</p>
<p>Personal Emergency Response System (PERS)</p>	<p>PERS is an electronic device that enables certain high-risk patients to secure help in the event of a physical, emotional, or environmental emergency. In the event of an emergency, the signal is received and appropriately acted on by a response center.</p>	<p>You must get PERS from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must get prior authorization from the Plan.</p>
<p>Private Duty Nursing</p>	<p>Provides home care aides, companion care, and</p>	<p>Services are covered when determined by the attending</p>

Service(s)	What Do I Get?	Coverage Rules
	homemaker services, and may include nursing services in your home or place of residence.	physician to be medically necessary. Nursing services may be intermittent, part-time or continuous. You must obtain prior authorization from the Plan. Services must be provided in accordance with the ordering physician, registered physician assistant, or certified nurse practitioner's written treatment plan. Services must be provided by a person possessing a license and current registration from the NYS Education Department to practice as a registered professional nurse or licensed practical nurse.
Prosthetics and Orthotics	Prosthetic appliances and devices are appliances and devices that replace any missing part of the body. Orthotic appliances and devices are appliances and devices used to support a weak or deformed body member, or to restrict or eliminate motion in a diseased or injured part of the body. Orthopedic footwear includes shoes, shoe modifications, or shoe additions that are used to correct, accommodate, or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot. Orthopedic footwear also is used to support a weak or deformed structure of the ankle or foot or to form an integral part of a brace.	These items may be covered by Medicare. You must get prosthetics, orthotics, and orthopedic footwear from an in-network MetroPlus UltraCare (HMO D-SNP) provider. You must get prior authorization from the Plan. Your doctor will need to provide signed written orders to the provider giving you these services. MetroPlus UltraCare (HMO D-SNP) will assist your provider in obtaining doctor's orders, if needed.
Social Day Care	Social Day Care is a structured program that provides	You must get Social Day Care from the MetroPlus UltraCare

Service(s)	What Do I Get?	Coverage Rules
	functionally impaired individuals with socialization, supervision, monitoring, and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include personal care maintenance and enhancement of daily living skills, transportation, caregiver assistance, and case coordination and assistance.	(HMO D-SNP) provider network, and you must obtain prior authorization from the Plan.
Social/Environmental Supports (such as chore services, home modifications or respite)	Social and environmental supports are services and items that support the medical needs of the member and are included in the member's plan of care. These services and items include but are not limited to: home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	You must get social and environmental supports from the MetroPlus UltraCare (HMO D-SNP) provider network, and you must get prior authorization from the Plan.

Health Related Social Needs (HRSN) Screening and Services

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

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

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

- Transportation services:
 - Helping you with access to public or private transportation to places approved by the SCN such as going to a job interview, parenting classes, housing court to prevent eviction, local farmers' markets, and city or state department offices to obtain important documents.
- Care management services:
 - Getting help with finding a job or job training program, applying for public benefits, managing your finances, and more.
 - Getting connected to services like childcare, counseling, crisis intervention, health homes program, and more.

Getting in Contact with a SCN in your area:

- 1) You may call MetroPlusHealth Member Services at 866.986.0356 (TTY users call 711), and we will connect you to a SCN in your area.
- 2) You may call the SCN within your county and request a screening or more information. See the SCN contact information in the chart below.
- 3) You may also visit their website to begin a self-screening.

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

SCN	Counties	Phone number
Public Health Solutions	Manhattan, Queens, Brooklyn	888.755.5045
	wholeyou.nyc	
Staten Island Performing Provider System	Richmond	917.830.1140
	statenislandpps.org/social-care-network/	
Somos Healthcare Providers, Inc.	Bronx	833.SOMOSNY (833.766.6769)
	somoscommunitycare.org/social-care-network	

COVERED BEHAVIORAL HEALTH (MENTAL HEALTH AND ADDICTION) SERVICES

Adult Outpatient Mental Health Care

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

Adult Outpatient Rehabilitative Mental Health Care

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may

include individual and group therapies at a clinic location in your community.

- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

Adult Outpatient Rehabilitative Mental Health and Addiction Services for Members Who Meet Clinical Requirements (these are also known as CORE)

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

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

Adult Mental Health Crisis Services

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

Adult Outpatient Addiction Services

- **Opioid Treatment Centers (OTP)** are Office of Addiction Services and Supports certified

sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

Adult Residential Addiction Services

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

Adult Inpatient Addiction Rehabilitation Services

- **State Operated Addiction Treatment Centers (ATC)** provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.
- **Inpatient Addiction Rehabilitation** programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.
- **Inpatient Medically Supervised Detox** programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

Telehealth

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

Getting Care Outside the Service Area

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

Emergency Service

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

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

Transitional Care Procedures

New enrollees in MetroPlus UltraCare (HMO D-SNP) may continue an existing person-centered service plan for a transitional period of up to ninety (90) days from enrollment, or until a new person-centered service plan is agreed upon between the new enrollee and MetroPlus UltraCare (HMO D-SNP), whichever is first.

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

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

Money Follows the Person (MFP)/Open Doors

Money Follows the Person (MFP)/Open Doors is a program that can help you move from a nursing home back into your home or residence in the community. You may qualify for MFP/Open Doors if you:

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

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

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

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 844.545.7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at health.ny.gov/mfp or www.ilny.org.

Section IV - MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that MetroPlus UltraCare (HMO D-SNP) does not cover, but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711) if you have a question about whether a benefit is covered by MetroPlus UltraCare (HMO D-SNP) or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy

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

The services listed below are services available through regular Medicaid.

Certain Mental Health Services, including:

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

For MAP enrollees up to the age of 21:

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

Certain Intellectual Disability and Developmental Disabilities Services, including:

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

Other Medicaid Services:

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

Family Planning:

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

Nonemergency Transportation

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

SERVICES NOT COVERED BY METROPLUS ULTRACARE (HMO D-SNP) or MEDICAID

You must pay for services that are not covered by MetroPlus Health Plan (HMO D-SNP) or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by MetroPlus Health Plan (HMO D-SNP) or Medicaid are:

- Cosmetic surgery, if not medically needed
- Personal and comfort items
- Services from a provider that is not part of the plan outside of a medical emergency (unless MetroPlus UltraCare (HMO D-SNP) authorizes you to see that provider)

If you have any questions, call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560.

Section V - SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

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

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page [33](#) for more information on the External Appeals process.

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

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

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you or your provider may call MetroPlus UltraCare (HMO D-SNP) Member Services at our toll-free number: 866.986.0356 (TTY: 711). Call Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. Or, send your request in writing to:

MetroPlus Health Plan
Utilization Management
50 Water Street, 7th fl.
New York, NY 10004

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

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from the UltraCare (D-SNP) Utilization Management department before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved **before** you get them:

- Inpatient Hospital Care
- Diagnostic Radiology Services (CT/MRI/MRA and PET Scans)
- Hearing Aids
- Comprehensive Dental Services
- Certain Medicaid-covered vision services
- Inpatient Mental Health Care
- Partial Hospitalization
- Skilled Nursing Facility
- Cardiac and Pulmonary Rehabilitation Services
- Supervised Exercise Therapy (SET)
- Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy)
- Nonemergency Ambulance Services
- Prosthetics/Medical Supplies and Durable Medical Equipment (DME)
- Diabetic Services and Supplies
- Medicare Part B Drugs
- Home Health Agency Care
- Home Infusion Therapy
- Opioid Treatment Program Services (inpatient services)
- Acupuncture (to treat chronic low back pain)
- Chiropractic Services
- Private Duty Nursing
- Personal Care Services
- Nutrition
- Medical Social Services
- Social and Environmental Supports
- Home-Delivered and Congregate Meals
- Adult Day Health Care
- Social Day Care
- Personal Emergency Response Services (PERS)
- Consumer Directed Personal Assistance Services (CDPAS)

- Nursing Home Care not covered by Medicare
- Podiatry

To get approval for these services or treatments, call our toll-free Member Services Help Line at 866.986.0356 (TTY: 711). You or your doctor may also submit a service authorization request by fax at 212.908.3126 or by mail to:

MetroPlus Health Plan
Utilization Management
50 Water Street, 7th fl.
New York, NY 10004

Concurrent Review

You can also ask MetroPlus UltraCare (HMO D-SNP) MetroPlus UltraCare (D-SNP) Utilization Management department to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request?

The health plan has a review team to be sure you get the services you qualify for. Doctors and nurses are on the review team. Their job is to be sure the treatment or services you asked for are medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

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

We will tell you and your provider both by phone and in writing if we approve or deny your requested amount. We will also tell you the reason for the decision. We will explain what options

you have if you don't agree with our decision.

Standard Process

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

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

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

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

Fast Track Process

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

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

- We will make a decision as quickly as we can once we receive the necessary information, but no later than fourteen (14) days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a fast complaint**. For more information about the process for making complaints, including fast complaints, see Section 4: *What To Do If You Have A Complaint About Our Plan*, below for more information. We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: *Level 1 Appeals*, below for how to make an appeal. To get a **fast service authorization**, you must meet two requirements:
 - 1) You are asking for coverage for medical care you have not gotten yet. (You cannot get a **fast service authorization** if your request is about payment for medical care you already got.)
 - 2) Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

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

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

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

- This letter will tell you that if your provider asks for the **fast service authorization**, we will automatically give a **fast service authorization**.
- The letter will also tell how you can file a **fast complaint** about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see Section 4: *What To Do If You Have A Complaint About Our Plan*, later in this chapter.)

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

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

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

Level 1 Appeals, below for more information.

If we are changing a service you are already getting

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

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

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

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

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- MetroPlus UltraCare (HMO D-SNP) can also explain the complaints and appeals processes available to you depending on your complaint. You can call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm (after-hours answering service: 800.442.2560) to get more information on your rights and the options available to you.

At any time in the process, you, or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 866.712.7197.

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

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

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

You can file a Level 1 Appeal:

If you are unhappy with a decision MetroPlus UltraCare (HMO D-SNP) makes, you can file an appeal. This is called a Level 1 appeal. Chapter 9 of your Medicare Advantage D-SNP *Evidence of Coverage* tells you how to file a Level 1 appeal on any decision MetroPlus UltraCare (HMO D-SNP) makes.

Aid to continue while appealing a decision about your care

If MetroPlus UltraCare (HMO D-SNP) reduces, suspends, or stops a service you are getting now, you may be able to continue the service while you wait for a Level 1 appeal determination.

You must ask for a Level 1 appeal:

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

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

If you are unhappy with your Level 1 appeal decision, you can appeal again. This is called a Level 2 appeal. Chapter 9 of your MetroPlus UltraCare (HMO D-SNP) *Evidence of Coverage* tells you how to file a Level 2 appeal on any decision MetroPlus UltraCare (HMO D-SNP) makes.

Aid to continue while waiting for a Fair Hearing decision

You may be able to continue your services while you wait for a Fair Hearing determination. Continuation of benefits is only available if MetroPlus UltraCare (HMO D-SNP) reduces, suspends, or stops a service, and the service is covered by Medicaid.

You must ask for a Fair Hearing:

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

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

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

Section 3: External Appeals for Medicaid Only

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

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

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

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

Before you appeal to the State:

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

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

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

- You can call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm (after-hours answering service: 800.442.2560), if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services at 800.400.8882
- Go to the Department of Financial Services website at dfs.ny.gov.

- Contact MetroPlusHealth at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560.

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

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

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 866.712.7197.

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

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

We hope our Plan serves you well. If you have a problem with the care or treatment you get from our staff or providers, or if you do not like the quality of care or services you get from us, call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560), or write to MetroPlus UltraCare (HMO D-SNP) Member Services. The formal name for making a complaint is filing a grievance.

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

How to File a Complaint:

- **Usually, calling MetroPlus UltraCare (D-SNP) Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711). Call Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560.
- If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
 - Send your written complaint to us at: MetroPlus Health Plan, Attn: Complaints Manager, 50 Water Street, 7th fl., New York, NY 10004.
- **Whether you call or write, you should contact MetroPlus UltraCare (HMO D-SNP) Member Services right away.** You can make the complaint at any time after you had the

problem you want to complain about.

What happens next:

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

Complaint Appeals

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

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

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

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

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 866.712.7197.

Participant Ombudsman

The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can call ICAN to get free, independent advice about your coverage, complaint, and appeal options. They can help you manage the appeal process.

ICAN can also provide support before you enroll in a Managed Long Term Care plan like MetroPlus UltraCare (D-SNP). This support includes unbiased health plan choice counseling and general plan related information.

Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
633 Third Ave, 10th Floor, New York, New York 10017
Web: icannys.org | Email: ican@cssny.org
Phone: 844.614.8800 (TTY Relay Service: 711)
9:00am - 5:00pm, Monday to Friday

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

Section VI - DISENROLLMENT FROM METROPLUS ULTRACARE (HMO D-SNP) MAP PROGRAM

Enrollees shall not be disenrolled from the MetroPlusHealth Medicaid Advantage Plus (MAP) product due to any of the following reasons:

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

You Can Choose to Voluntarily Disenroll

You can ask to leave the MetroPlus UltraCare (D-SNP) MAP program at any time for any reason.

To request disenrollment, call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. It could take up to six (6) weeks to process, depending on when your request is received. You may disenroll to regular Medicaid, or join another health plan as long as you qualify. If you continue to require CBLTSS, like personal care, you must join another MLTC Plan or Home and Community Based Waiver program, in order to continue to receive CBLTSS services.

You Will Have to Leave MetroPlus UltraCare (HMO D-SNP), MAP program if:

- You no longer are enrolled in MetroPlus UltraCare (HMO D-SNP) for your Medicare coverage,
- You no longer are Medicaid-eligible, because:
 - You need nursing home care, but are not eligible for institutional Medicaid,
 - You are out of the Plan's service area for more than thirty (30) consecutive days,
 - You permanently move out of the MetroPlus UltraCare (HMO D-SNP) service area,
 - You are a MLTC Legacy Status enrollee and you no longer are eligible for nursing home level of care as determined using the CHA, unless the termination of the services provided by the Plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period,
 - At the point of any reassessment while living in the community, you are determined to no longer meet the Minimum Needs ADL requirement,
 - You have not received one of the CBLTSS services such as adult day health care, private duty nursing, home health aide services, CDPAS, or services in the home including personal care services (Level 2), nursing services or therapies. Please note that Social Adult Day Care services alone do not qualify you for continued enrollment,
 - You join a Home and Community Based Services waiver program, or become a

- resident of an Office for People with Developmental Disabilities residential program,
- You become a resident of an OMH or OASAS residential program (that is not a MAP plan covered benefit) for forty-five (45) consecutive days or longer, or
- You refused to complete a required reassessment.

We May Ask You to Leave the MetroPlus UltraCare (HMO D-SNP), MAP program if:

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

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

Section VII - CULTURAL AND LINGUISTIC COMPETENCY

MetroPlus UltraCare (HMO D-SNP) honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

Section VIII - MEMBER RIGHTS AND RESPONSIBILITIES

MetroPlus UltraCare (HMO D-SNP) will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort in assisting you with exercising your rights.

Member Rights

- You have the right to receive medically necessary care.
- You have the right to timely access to care and services.
- You have the right to privacy about your medical record and when you get treatment.

- You have the right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the right to get information in a language you understand; you can get oral translation services free of charge.
- You have the right to get information necessary to give informed consent before the start of treatment.
- You have the right to be treated with respect and dignity.
- You have the right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the right to take part in decisions about your health care, including the right to refuse treatment.
- You have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- You have the right to get care without regard to gender, race, health status, color, age, national origin, sexual orientation, marital status, or religion.
- You have the right to be told where, when, and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the right to complain to the New York State Department of Health or your Local Department of Social Services; and the right to request a fair hearing through the Office of Administrative Hearings and/or a New York State External Appeal, where appropriate.
- You have the right to appoint someone to speak for you about your care and treatment.
- You have the right to seek assistance from the Participant Ombudsman program.

Member Responsibilities

- You have the responsibility to receive covered services through MetroPlus UltraCare (HMO D-SNP).
- You have the responsibility to use MetroPlus UltraCare (HMO D-SNP) network providers for these covered services, to the extent network providers are available.
- You have the responsibility to obtain prior authorization for covered services, except for pre-approved covered services or in emergencies.
- You have the responsibility to be seen by your physician if a change in your health status occurs.
- You have the responsibility to share complete and accurate health information with your health care providers.
- You have the responsibility to inform MetroPlus UltraCare (HMO D-SNP) staff of any changes in your health, and making it known if you do not understand or are unable to

follow instructions.

- You have the responsibility to follow the plan of care recommended by the MetroPlus UltraCare (HMO D-SNP) staff (with your input.)
- You have the responsibility to cooperate with and be respectful with MetroPlus UltraCare (HMO D-SNP) staff and not discriminate against MetroPlus UltraCare (HMO D-SNP) staff because of race, color, national origin, religion, gender, age, mental or physical ability, sexual orientation, or marital status.
- You have the responsibility to notify MetroPlus UltraCare (HMO D-SNP) within two business days of receiving noncovered or non-pre-approved services.
- You have the responsibility to notify your MetroPlus UltraCare (HMO D-SNP) health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- You have the responsibility to inform MetroPlus UltraCare (HMO D-SNP) before permanently moving out of the service area, or of any lengthy absence from the service area.
- You have the responsibility for the consequences of your actions if you refuse treatment or do not follow the instructions of your caregiver.
- You have the responsibility to meet your financial obligations.

Advance Directives

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

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

Information Available on Request

- Information regarding the structure and operation of MetroPlus UltraCare (HMO D-SNP).
 - Specific clinical review criteria relating to a particular health condition and other information that MetroPlus UltraCare (HMO D-SNP) considers when authorizing services.
- Policies and procedures on protected health information.
 - Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.

- Provider credentialing policies.
- A recent copy of the MetroPlus UltraCare (HMO D-SNP) certified financial statement; and policies and procedures used by MetroPlus UltraCare (HMO D-SNP) to determine eligibility of a provider.
 - MetroPlus UltraCare (HMO D-SNP) provides free aids and services to people with disabilities to help you communicate with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats). If you need these services, call MetroPlus UltraCare (HMO D-SNP) Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm. After-hours answering service: 800.442.2560. The call is free.

Electronic Notice Option

MetroPlus UltraCare (HMO D-SNP) and our vendors can send you notices about service authorizations, plan appeals, complaints, and complaint appeals electronically, instead of by phone or mail. We can also send you communications about your member handbook, our provider directory, and changes to Medicaid managed care benefits electronically, instead of by mail.

We can send you these notices to you by web portal.

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

- Phone.....866.986.0356 (TTY: 711)
- Email.....help.memberexperience@metroplus.org
- Online.....metroplus.org/forms/contact-Us
- Mail.....MetroPlus Health Plan
50 Water Street, 7th fl.
New York, NY 10004

When you contact us, you must:

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

MetroPlus UltraCare (HMO D-SNP) will let you know by mail that you have asked to get notices electronically.

**Notification for MAP Member Handbook Insert
Regarding the Unified Plan-level Appeals and Grievance Process
LETTER FROM PLAN TO MEMBERS**

Dear MetroPlus UltraCare member:

This mailing is letting you know about an important update to your member handbook. The update will be available on our website at metroplusmedicare.org. Please read this update carefully. The MAP appeals and grievance process is changing. These changes take effect January 1, 2026.

The member handbook update tells you about:

1. What is changing between now and December 31, 2025?
2. What is changing on January 1, 2026?
3. Do I still get External Appeal rights for Medicaid covered benefits?
4. Where can I get more information?

A quick reference guide about these changes is attached. Please call Member Services at 866.986.0356 (TTY: 711), Monday to Friday, 8am to 8pm, and Saturday, 9am to 5pm (after-hours answering service: 800.442.2560) if you:

- have any questions about this information;
- cannot access the internet to view the handbook update; or
- want to have the handbook update mailed to you.

Please keep this update with your **MetroPlus UltraCare (HMO D-SNP)** member handbook.

Sincerely,

MetroPlusHealth

Important Change for Medicaid Advantage Plus Member Appeals

What is changing between now and December 31, 2025?

There are no changes to the Level 2 Appeal process until the end of 2025. If we deny your Level 1 Appeal (also known as a Plan Level Appeal), your case will **automatically be sent for a Level 2 Appeal** with the Hearing Office.

What is changing on January 1, 2026?

The way you request a Level 2 Appeal will change. Beginning in January 2026, if you lose the Level 1 Plan appeal, your next appeal steps will depend on whether the service is covered by Medicare or Medicaid. We will send you a written notice called an “*Appeal Decision Letter*,” which will tell you that you lost your Level 1 Appeal.

If the service is covered by Medicaid:

A Level 2 Appeal for services covered by Medicaid is also known as a Fair Hearing. Starting on January 1, 2026, if you lose your Level 1 Appeal, and the benefit is covered by Medicaid, you or your authorized representative must ask the State for a Level 2 (Fair Hearing) Appeal. You will have 120 days to ask for a Level 2 Fair Hearing Appeal.

- **How have Level 2 Appeals changed?**

Prior to January 1, 2026 when your Level 1 Plan Appeal was denied, a Level 2 Appeal was automatically requested for you. You did not have to request a Level 2 Appeal yourself.

If we are reducing, suspending, or stopping the Medicaid services you are getting right now and you want your services to stay the same while you wait for a Level 2 Fair Hearing Appeal decision, you must ask for the Level 2 Fair Hearing Appeal within 10 calendar days from the Level 1 Appeal decision or by the date the appeal decision takes effect, whichever is later. Your services will stay the same until the Level 2 Fair Hearing Appeal decision. If you lose your Level 2 Fair Hearing Appeal, you may have to pay for services you got while waiting for the decision.

If the service is covered by Medicare:

If you lose your Level 1 Appeal, and the benefit is covered by Medicare, we will automatically send your case to Level 2 of the Medicare appeal process to be reviewed by an Independent Review Entity (IRE), as soon as your Level 1 appeal is complete.

If the service is covered by Medicare and Medicaid:

If you lose your Level 1 Appeal, and the benefit is covered by both Medicare and Medicaid, we will automatically send your case to the IRE and you can also ask for a Level 2 Fair Hearing Appeal.

Do I still get External Appeal rights for Medicaid covered benefits?

Yes, if we said the service is not medically necessary, experimental, or investigational, and not different from care you can get in our network or available from a participating provider who has the correct training and experience to meet your needs, then you can still ask the

State for an External Appeal. You will have four months to ask for an External Appeal. If you ask for both a Fair Hearing and an External Appeal, the Fair Hearing decision will always be the final answer.

Where can I get more information?

Call Member Services at 866.986.0356 (TTY: 711). Hours are Monday through Friday, 8am to 8pm, and Saturday, 9am to 5pm. (After-hours answering service: 800.442.2560). See Chapter 9 of your *Evidence of Coverage* (EOC) for full information about your appeal rights and how to file an appeal.

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Phone: 844.614.8800 (TTY Relay Service: 711)

Web: icannys.org | **Email:** ican@cssny.org

Does this change to Member Appeals change my benefits or enrollment?

This change to Member Appeals does not change my benefits or enrollment.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-800-303-9626 (TTY: 711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-800-303-9626 (TTY: 711).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-800-303-9626 (TTY: 711)。	Chinese Traditional
1-800-303-9626 (TTY: ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم (711).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-800-303-9626 (TTY: 711) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-800-303-9626 (TTY: 711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-800-303-9626 (TTY: 711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-800-303-9626 (TTY: 711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-800-303-9626 (TTY: 711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר איך אומזיסט. 1-800-303-9626 (TTY: 711) רופט	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-800-303-9626 (TTY: 711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-800-303-9626 (TTY: 711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-800-303-9626 (TTY: 711)-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-800-303-9626 (TTY: 711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-800-303-9626 (TTY: 711).	Greek
1- توجه فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں۔ 800-303-9626 (TTY: 711)	Urdu
LƯU Ý: Có dịch vụ hỗ trợ ngôn ngữ và các hỗ trợ khác miễn phí cho quý vị. Vui lòng gọi 1-800-303-9626 (TTY: 711).	Vietnamese

LANGUAGE ASSISTANCE

ACHTUNG: Sprachassistenzen und andere Hilfen stehen Ihnen kostenlos zur Verfügung. Rufen Sie 1-800-303-9626 an (TTY: 711).	German
請注意：您可免費取得語言協助服務及其他輔助服務。請撥打 1-800-303-9626 (TTY: 711 聽障專線)。	Chinese Simplified
ध्यान दें: भाषा संबंधी सहायता सेवाएँ और अन्य सहायता आपके लिए मुफ्त में उपलब्ध हैं। 1-800-303-9626 (TTY: 711) पर कॉल करें।	Hindi
Estão disponíveis, gratuitamente, serviços de assistência linguística e outras formas de apoio. Ligue para 1-800-303-9626 (TTY: 711).	Portuguese
注意：無料の言語支援サービスやその他のサポートをご利用いただけます。1-800-303-9626 (TTY: 711) までお電話ください。	Japanese





50 Water St., 7th Floor • New York, NY 10004



METROPLUSMEDICARE.ORG

866.986.0356 • TTY: 711