



Member Handbook

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FOR PROSPECTIVE MEMBERS

Eligibility for Enrollment

You are eligible to join Integra's MLTC program if you meet the following requirements:

- Are age 18 or older;
- Reside in Integra's service area (Bronx, Manhattan, Brooklyn, Queens, Staten Island, Nassau, Suffolk, or Westchester);
- Are eligible for Medicaid as determined by the Local Department of Social Services (LDSS) or New York City Human Resources Administration (HRA);
- Are aged 18-20 or not eligible for both Medicare and Medicaid (non-dual eligible), **and** eligible for a nursing home level of care;
- Are 21 or older, eligible for both Medicare and Medicaid (dual eligible), and have been determined eligible for a nursing home level of care;
- Are expected to need one or more of the following community-based long term care services for more than 120 days from the date that you join our plan:
 - 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
 - Consumer Directed Personal Assistance Service
- You are able to return to or remain at home and in your community without jeopardy to your health and safety at the time of enrollment;
- If you were previously involuntarily disenrolled and would like to return

to Integra's Managed Long Term Care Plan, then Integra will review your case for possible re-enrollment.

If you are not Medicaid eligible due to excessive income, but have ongoing health care expenses such that you would be spending down the income above the amount allowable for Medicaid eligibility, you will be deemed Medicaid eligible so long as you make monthly payments to Integra of the "spend-down" amount determined by the LDSS.

Individuals Excluded from Enrollment

The following individuals are ineligible for enrollment in Integra MLTC:

- Individuals eligible for Medicaid benefits only with respect to tuberculosis-related services;
- Individuals eligible for Medicaid benefits only with respect to breast and cervical cancer services;
- Individuals eligible for the family planning expansion program;
- Individuals under age sixty-five (65) who are in the Centers for Disease Control and Prevention breast and/or cervical cancer early detection program, need treatment for breast or cervical cancer, and are not otherwise covered under creditable health coverage;
- Individuals expected to be Medicaid eligible for fewer than six (6) months;
- Individuals eligible to live in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), but who choose not to do so;
- Individuals receiving Limited Licensed Home Care Services;
- Individuals in the Foster Family Care Demonstration Program;
- Individuals eligible for Emergency Medicaid;
- Individuals currently hospitalized or living in a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and

Substance Abuse Services (OASAS) or the State Office for People with Developmental Disabilities (OPWDD);

- Individuals enrolled in another Medicaid managed care plan, a Home and Community-Based Services waiver program or OPWDD facility or waiver program;
- Individuals receiving services from a hospice at the time of enrollment.

Enrollment Process

The enrollment process will determine your eligibility for the program and ensure that you are making an informed decision. We take pride in performing our role in this process in a manner that is as convenient as possible for prospective members.

Verification of Interest Call

We will contact you by phone in order to confirm your interest in joining Integra and to gather information that is relevant to the scheduling of your in-home assessment. We will also answer any questions you might have about the assessment and Integra's program at this time.

If necessary, we will transfer you to the Conflict Free Evaluation and Enrollment Center (CFEEC). You will need an assessment by the CFEEC if you are joining an MLTC for the first time, if you have not been in an MLTC plan for forty-five (45) days or longer, or if too much time has elapsed since an earlier CFEEC evaluation. You do not need a CFEEC evaluation if you are already receiving Medicaid home care outside of a managed care plan or if you are already enrolled in an MLTC plan and would like to switch to Integra.

CFEEC Assessment

The CFEEC is a program of New York State Medicaid, and is independent of Integra or any other MLTC plan. It is responsible for scheduling and

performing the in-home assessment that will determine whether you are eligible to join Integra or any other MLTC.

Once you are connected with the CFEEC, a Counselor will schedule the assessment. You will be asked to confirm your full name, address, birth date, phone number, and Medicaid ID or Social Security Number, so be sure to have this information handy. The CFEEC should be able to schedule the assessment within five (5) to (7) business days.

A CFEEC Registered Nurse will then visit you at your home at the appointed time to conduct the assessment, which takes about three (3) hours. Afterwards, you will be informed whether you qualify for long term care. If you believe that you qualify and the nurse disagrees, you can request a Fair Hearing in order to appeal the nurse's decision (see "State Fair Hearings" under "Actions and Appeal of Actions" below).

To schedule an in-home assessment with the CFEEC:

Monday through Friday 8:30 AM to 8:00 PM
Saturday 10 AM to 6 PM

Call 1-855-222-8350 (TTY: 1-888-329-1546),
CFEEC counselors are fluent in all languages.

Integra's Pre-Enrollment Assessment

Once it is determined you are eligible to join a long-term care plan, Integra will schedule your in-home assessment to establish the most appropriate and effective plan of care for you. This will be conducted by one of our Registered Nurses and will take place within thirty (30) days of your initial contact with Integra.

At the time of the assessment, the Assessment Nurse will answer questions you or your caregiver may have and make sure that your decision to enroll

in Integra is an informed one. If you decide to enroll, you will complete the enrollment agreement and associated paperwork, and we will let you know when you can expect your enrollment with Integra to start. You will receive a copy of the Provider Directory, which lists all providers available in the Integra network. The coverage explained in this Handbook begins the effective date of your enrollment with Integra.

The choice of Integra as your Managed Long Term Care plan is completely voluntary on your part. At any time before or during the enrollment process, you can change your mind and withdraw your application. Even after you have completed the application process, you can withdraw from the plan orally or in writing until noon of the 20th day of the month preceding the start date of your enrollment. (So if you were scheduled to start your membership March 1st, you can withdraw until noon on February 20th.) After this point, you will still be able to leave the plan by requesting disenrollment.

Information about your Integra benefits and everything you need to know to make the most of your enrollment is provided in this Handbook. We encourage you to review it and keep it for future reference.

FOR ENROLLED MEMBERS

Introduction to Integra & Benefits of Integra Membership

Welcome to Integra MLTC, Inc. We are pleased you chose us as your Managed Long Term Care Plan (MLTC) and want to ensure you have a beneficial experience with us. Integra is committed to serving our members in ways that earn trust and loyalty.

Integra MLTC, Inc. (“Integra”) is a New York State approved Medicaid Managed Long Term Care Plan operating in the five counties of New York City, Nassau, Suffolk, and Westchester counties. Integra is part of Personal Touch, a company that brings more than 40 years of experience caring for people in their homes. Our program is specifically designed for people like

you who are eligible for Medicaid and in need of health and long term care services, such as home care and personal care. We are committed to helping you stay healthy, safe, and living independently in the comfort of your own home.

How to Use This Handbook

The Member Handbook will provide you with the guidance you need to make the most of your enrollment with Integra. Here you will find information on the services available to you, how to access these services, your rights and responsibilities as a member of Integra, and what to do when you have an issue with the care you receive, including filing a grievance or appeal, or initiating disenrollment.

Updates we make to the Member Handbook will be sent to you, and another copy of the Member Handbook can be requested by calling Member Services' Toll Free Number 1-855-661-0002 / TTY 711. An electronic copy of the Member Handbook will also be posted on Integra's website.

Please take the time to familiarize yourself with this Handbook and keep it available for future reference. We hope it will be a helpful resource for you.

Benefits of Integra Membership

Dedicated Team Assigned to Your Care

As an Integra member, you will have a dedicated Care Management Team that includes a Registered Nurse, Social Worker, and Coordinator who will work with you and your loved ones to ensure all your long term care needs are met. Beginning with your pre-enrollment assessment, the Team will work with you to determine your needs and design a Person-Centered Service Plan (PCSP) to address them. We also make sure that you and your loved ones understand and agree with the plan for your care and

services. Additionally, the Team regularly monitors your services to ensure they are meeting your needs, and we listen to you and your loved ones for any feedback. As your needs change, the Care Management Team is there to make appropriate adjustments to your services. In this way, your Care Management Team is your partner in staying healthy, safe, and independent.

Access to Integra's Network of Providers

Through Integra, you will have access to a wide array of services that can be tailored to meet your needs: we are your one-stop shop for accessing needed long term care services. To give you high quality care, we work closely with a wide variety of providers who have chosen to work with Integra by joining our network. These providers have gone through special training and orientation in order to participate in our network, and we continually add providers to our network to ensure that our members have adequate choice of providers.

You should have received a copy of Integra's Provider Directory, which lists all in-network providers at your pre-enrollment assessment. If you do not have one or would like an additional copy, call Member Services Toll Free Number 1-855-661-0002 / TTY 711, or visit our website, www.integraplans.org.

Coordination with Your Health Care Providers

Integra will work with your health care providers to help coordinate your long term care, including hospital and physician services. If you have physician(s) you see regularly, you do not need to make any change; you can continue to get care from them. We are here to help make sure that you receive the care you need, ensuring you have the necessary means to get to your appointments, talking with your doctor(s) to find out how we can support you in your home to manage your medical condition, and staying in communication with them to make sure that your issues and concerns are

being addressed timely and appropriately. We strive to make your care seamless and less burdensome for you and your loved ones to manage.

Health Education

Integra is committed to developing your understanding of the health care system and your medical condition(s), and will regularly provide you with patient educational material by mail. Past mailings have addressed subjects such as diabetes management, advance directives, high blood pressure, and immunizations.

Your Welcome Packet and Integra ID Card

All newly enrolled members receive a Welcome letter and an Integra Member ID card.

Your Integra Member ID Card is stamped with your Member ID number, Medicaid Client Identification Number, and Integra's telephone numbers. Be sure to carry this card with you at all times, as you will need it before receiving care from Integra network providers. If you lose your member ID card, you can call Member Services' Toll Free Number 1-855-661-0002 / TTY: 711 to request a replacement card.

 INTEGRA <i>Managed Care</i>	
John Smith	
Member ID: IT001234567	
Medicaid CIN PN12345F	
Member Since 3/1/2017	
<hr/>	
Member Services: 1-855-661-0002	

Member ID Card- front

<p>FOR MEMBERS: Prior Authorization is required for certain services. Please consult your Member Handbook, or contact your Care Manager or Member Services 1-855-661-0002 for further assistance. TTY/TDD users, call 711. For further information, visit www.integrplan.org Dental / Healthplex: 1-800-468-9868 Vision / DavisVision: 1-800-999-5431</p> <hr/> <p>For Providers: This ID Card does not guarantee member eligibility or payment. Check E-PACES for member eligibility or call 1-347-505-3412 to confirm eligibility and obtain authorization PRIOR to rendering service.</p> <p>Submit paper claims for MLTC Services to: Integra MLTC, Inc. C/O RelayHealth, 1564 Northeast Expressway, Mail Stop HQ 2361, Atlanta, GA 30329. For electronic claims, submit to Change Healthcare. For claims inquiry, call 866-775-8860. For more information, call Provider Services at 1-347-505-3429 or visit www.integrplan.org.</p> <p>Healthplex Providers: 1-888-468-2183 DavisVision Providers: 1-800-773-2847</p>

Member ID Card- back

Note that when you seek care from your health care provider or to obtain services that Integra does not cover, you will still require your health insurance ID card (Medicare Advantage plan ID, or Medicare and Medicaid benefit cards).

Welcome Letters from Our Dental & Vision Care Partners

During your first month of enrollment with Integra, you will receive a welcome letter from HealthPlex, our dental care partner, and DavisVision, our vision care partner. These will introduce your dental and vision care benefits and detail how to access the services.

If you have questions regarding your vision and dental benefits, you can call the numbers provided in these letters, or you can contact Integra Member Services. (Toll Free Number 1-855-661-0002 / TTY: 711).

Help from Member Services

Our members and their care are always at the center of Integra's focus and Member Services is a big part, always glad to provide the help you need in order to make the most of your enrollment with Integra.

If you cannot find the information you are looking for in this Handbook or you need someone to explain it for you, call Member Services. They can explain benefits and services, help you find a provider, schedule a medical appointment, replace a lost ID card, or send you copies of the Member Handbook and/or Provider Directory. Member Services is also glad to discuss any concerns you may have about your care, and they can help you file complaints about your care or a service provider. Additionally, Member Services can explain your rights and responsibilities and help you understand Integra's policies. You may request language translation or other communication assistance when you call.

Member Services is available:

Monday through Friday
8 am to 5 pm

Toll Free: 1-855-661-0002

TDD/TTY: 711

After-Hours
Weekdays before 8am or after 5pm, weekends, or holidays

Toll Free: 1-855-661-0002

TDD/TTY: 711

If your need cannot be immediately addressed after hours, you will receive assistance the next business day.

Members Whose Primary Language is Not English

Integra is committed to communicating with you in your preferred language. We have employees fluent in several languages and are able to access outside interpreter services if necessary. Integra ensures you receive the information you need and that your questions and concerns are adequately addressed. If you need member materials and communications in another language, we will make them available to you. We can also help you find providers who speak your language.

Members with Disabilities

Integra ensures its disabled members receive any necessary assistance to maximize the benefits of their membership.

Physically Disabled Members

Member Services can supply you with information about whether a provider office is wheelchair accessible, and find you a provider who can otherwise accommodate your needs. Member Services can also arrange for any needed special transportation arrangements.

Visually Impaired Members

Large print versions of our literature (including this Handbook) are available for members with visual impairment, and some of our materials are available on audiotape or CD. Additionally, our Member Services Representatives are glad to read you the contents of any materials or documents you need help with.

Hearing Impaired Members

Members who are hearing impaired may contact Member Services using our TDD/TTY: 711. Our Member Services Relay Operator is also glad to assist you in making calls to a health care provider.

Your Rights as an Integra Member

Members of Integra's MLTC plan have the following 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, and 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 sex, 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, as well as the Right to use the New York State Fair Hearing System 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.

Your Responsibilities as an Integra Member

It is important that you become familiar with your responsibilities as a member of Integra, as outlined in this section:

- You are responsible to help Integra keep accurate personal data about you, including changes in name, address, phone number, additional health insurance carriers, and an increase or decrease in dependents within thirty (30) days of the change.
- You are responsible to treat with consideration and courtesy all Integra personnel and the personnel of any agency or long term care provider to which you are referred.
- You are responsible to be actively involved in your own long term care by seeking and obtaining information, by discussing treatment options with your Care Management Team, and by making informed decisions about your long term care.

- You are responsible to follow plans and instructions for care that you have agreed to with your practitioner.
- You are responsible to participate in the development and updating of your care plan.
- You are responsible to comply with all requirements of Integra as outlined in your Member Handbook.
- You are responsible to request and receive all of your medically necessary covered benefits through Integra.
- You are responsible to make every effort to pay Integra any Medicaid surplus amount owed.
- You are responsible to maintain Medicaid eligibility.
- You are responsible to notify Integra's Care Management Team when you are leaving the service area, if you have moved or have a new telephone number, if you have changed doctors, or if there are any changes in condition that may affect our ability to coordinate your care.

Ombudsman Program

The Participant Ombudsman is the Independent Consumer Advocacy Network (ICAN), an independent network of consumer advocacy organizations. ICAN provides free ombudsman services to long term care recipients in the state of New York, answering questions regarding enrollee rights, Medicare, Medicaid, and long term care services. ICAN can also assist enrollees with resolution of any issues related to access to care and with filing appeals and grievances.

Contact ICAN:

Toll free: 1-844-614-8800

TTY Users: call 711 and follow the prompts to dial 844-614-8800

E-mail: ican@cssny.org

Find out More about ICAN: <http://icannys.org>

CARE MANAGEMENT SERVICES

Our goal is to assist you in the management of your health and quality of life in order that you might be as independent and comfortable as possible in your home. One of the great benefits of enrollment with Integra is having the knowledge that you need only call one number to arrange for all of your medically necessary care and services.

Your Care Management Team

As a member of Integra, you will have a dedicated team of care management professionals who will be assigned to your care for as long as you are enrolled with us. This team of professionals will work with you, your family, and your health care provider(s) to determine your services and develop a care plan tailored to meet your specific needs. The Care Management Team will arrange for services and work with health and long term care providers to coordinate all aspects of your care. The Care Management Team also

works with nurses who make periodic visits to your home to monitor and assess your care needs, ensuring that your care plan is updated as your needs change over time. You have access to your Care Management Team at all times during normal hours of operations and to an on-call Care Manager outside normal business hours.

You will be assigned a Care Management Team within fourteen (14) days of enrollment. We will do our best to match you to the team that can best meet any special needs you might have, including any need to communicate in a language other than English. Integra will send you a notice providing information about your Team, and your Care Manager will follow up with an outreach call to introduce him/herself to you and explain how the Care Management Team will be working with you.

Your Team will include, but is not limited to, a Care Manager (a Registered Nurse), a Service Coordinator, and a Social Worker. The Team is supported by the Assessment Nurse and Care Management Team Supervisor.

Care Manager (RN)

The Care Manager is responsible for coordinating communications between and among you and all of the providers responsible for your care. Your Care Manager will:

- Review your medical status, identify and follow up on any issues concerning your long term care;
- Serve as your primary contact with the agencies providing you services;
- Follow up with your physicians on any medical issues you may have;
- Monitor your medications;
- Counsel and explain your medical issues to both you and your family members, and provide education/coaching on how you and your family can help manage your care;
- Contact you monthly to check on your status and progress; and

- Update and maintain your case records.

Social Worker

The Social Worker will serve as your primary contact for your behavioral, social, or psychological health services. Your Social Worker will:

- Discuss with you any social, family, psychological, and behavioral issues;
- Serve as primary contact with your behavioral health service providers;
- Identify and help you gain access to community resources;
- Counsel you on social service issues and provide education/coaching to help you and your family to manage your care giving.

Service Coordinator

The Service Coordinator is the person responsible for setting up your appointments and arranging for any of the in-home services you will receive. Working with your physician, therapists, health care providers, and other vendor/agency/service providers, the Service Coordinator will coordinate necessary services in the most efficient way possible in order to address all of your long term care needs. Specifically, the Service Coordinator will:

- Assist you in setting up appointments with providers and arranging for in-home services that are part of your long term care plan;
- Assist in making transportation arrangements for appointments with providers;
- Follow up with providers to assure you receive needed services and to document the care given;
- Provide you with any information you request concerning your care or services:

- Serve as your primary contact with Integra's Member Services Department;
- Make sure that all of your records and files are properly maintained.

Person Centered Service Plan (Plan of Care)

The Person Centered Service Plan is a written document detailing the specific type of care and services you will receive to help maintain and improve your health status and keep you as independent as possible.

The initial Plan of Care will be developed by your Care Management team and will take into account the following:

- The comprehensive set of assessments conducted by Integra's Assessment Nurse during his/her visit to your home and the resulting Interim Service Plan;
- Your relevant medical history and current health status/condition;
- Consultation with your primary care physician, and, if necessary, any other health care providers involved in your care;
- Input from you, your family, and/or other support networks.

At Integra, we are serious about engaging our members in care planning and care management. The Care Management Team will consult with you and your family/caregiver or representative when developing the care plan. We consider you to be an important and vital part of the health care delivery team. You are encouraged to discuss your health care needs with your treating physicians and with your Care Management Team to ensure that the care plan accurately reflects the services required, incorporates your preferences, and addresses any potential barriers to effective care plan execution.

The Person Centered Service Plan lists both covered and non-covered services Integra will be providing and/or coordinating for you. It will detail the

type, duration, and frequency of services authorized. Your Care Management Team will make arrangements for your services and select appropriate providers, consulting with you during the process to ensure your preferences and/or special needs are taken into consideration. Your team will also assist in arranging necessary non-covered services and coordinating with appropriate providers.

Care Monitoring, Re-assessments, and Care Plan Updates

Your Care Management Team will be in regular contact with you to find out how you are, assess how the services you are receiving are working, and to discuss any concerns or issues you might have. The Team will closely monitor any medical issues you may be experiencing and work with your health care providers and Integra's service providers to ensure that your changing needs are being timely and appropriately addressed. At times, we may need to visit you at home to conduct assessments so that we can adjust your care plan to provide the right set of services. If you require additional services, different services, or an increase or decrease in the frequency of your current services, the appropriate adjustments will be made with your input. Your Care Manager will discuss any proposed changes with you and any other individuals or agencies that will be involved. We will do this as often as necessary, but in no event will we visit you in person less than once every six (6) months or contact you by phone less than once a month. As long as you are a member of Integra, you can count on your Care Management Team to be on top of your care.

Continuity of Care

Community-Based Long Term Services and Supports (CBLTCS)

If you were receiving community-based long term services and supports under Medicaid fee-for-service prior to enrollment with Integra, you will continue to receive these services for either ninety (90) days after enrollment or until an assessment has been completed by Integra,

whichever is later. Community-based long-term services and supports (CBLTCS) are health care and supportive services provided to individuals of all ages with functional limitations or chronic illnesses that require assistance with daily activities. This includes services such as Home Health Services, Private Duty Nursing, Consumer Directed Personal Assistance Services, Adult Day Health Care Program, and Personal Care Services. Included in these services is care such as assistance with bathing, assistance with dressing, help preparing your meals, and assistance with medications.

If Integra terminates, reduces, suspends, or otherwise restricts access to these pre-existing services, you will receive official notification from Integra, and will have the right to a fair hearing and external appeal, as well as the right to have the disputed services continued while the request is processed (see “State Fair Hearings” and “State External Appeals” in “Actions and Appeals of Actions” section).

Money Follows the Person (MFP)/Open Doors

MFP/Open Doors is a program that can help enrollees move from a nursing home back into their home or residence in the community. Enrollees may qualify for MFP if they:

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

Transition Specialists and Peers are representatives of the MFP/Open Doors program who will actually meet with enrollees in the nursing home and talk with them about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help enrollees by:

- Giving them information about services and supports in the community;

- Finding services offered in the community to help enrollees be independent;
- Visiting or calling enrollees after they move to make sure that they have what they need at home.

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, contact the New York Association on Independent Living:

By phone: 1-844-545-7108

E-mail: mfp@health.ny.gov

You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

YOUR MANAGED LONG TERM CARE BENEFITS

Integra offers a wide range of long term care and supportive services as part of your covered benefits. You may get the services described below as long as they are medically necessary, that is, if they are needed to prevent or treat your illness or disability. 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. Your Care Manager will also work with your health care providers to coordinate other “non-covered benefits” such as hospital, physician, or diagnostic services.

What does “Medically Necessary” mean?

A service is deemed “medically necessary” if it is necessary to prevent, diagnose, correct, or cure a condition of yours that causes acute suffering, endangers life, results in illness or infirmity, interferes with your capacity for normal activity, or threatens some significant handicap.

What does “Covered Benefits” mean?

These are benefits and services that are approved through your membership in Integra, are usually performed or delivered by a network provider, and are paid for by Integra. The specific services as well as the frequency and duration of these services will be approved based upon your Care Manager’s assessment of your medical, physical, and social needs. Integra will arrange all medically necessary covered services on your behalf.

What does “Coordinated Non-Covered Benefits” mean?

These are benefits and services that are **NOT** covered by Integra. Although coordinated services are not paid for by Integra, Integra’s care management staff may assist members to access them. You may choose any provider you like (the provider does not have to be a network provider), as long as that provider accepts Medicare, Medicaid, your third party insurance, or you pay privately.

Covered and Coordinated Services

Covered Services (Covered by MLTC capitation)	Non-Covered Services (Billed Medicaid fee-for-service)
Care Management	Inpatient Hospital Services
Nursing Home Care (Residential Health Care Facility)	Outpatient Hospital Services
Home Care a. Nursing b. Home Health Aide c. Physical Therapy (PT) d. Occupational Therapy (OT) e. Speech Pathology (SP) f. Medical Social Services	Physician Services including services provided in an office setting, a clinic, a facility, or in the home
Adult Day Health Care	Laboratory Services
Personal Care	Radiology and Radioisotope Services
DME* – including Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries, Prosthetics, Orthotics, and Orthopedic Footwear	Emergency Transportation
Personal Emergency Response System	Rural Health Clinic Services
Non-emergent Transportation	Chronic Renal Dialysis
Podiatry*	Mental Health Services
Dentistry	Alcoholism and Substance Abuse Services
Optometry/Eyeglasses	OPWDD Services
PT, OT, SP or other therapies provided in a setting other than a home.* Limited to 20 visits of each therapy type per calendar year, except for children under 21 and the developmentally disabled. MLTC plan may authorize additional visits.	Family Planning Services
Audiology/Hearing Aids*	Prescription and Non-Prescription Drugs, Compounded Prescriptions
Respiratory Therapy	Hospice Services
Nutrition	All other services listed in the Title XIX State Plan
Private Duty Nursing	
Consumer Directed Personal Assistance Services	
Telehealth	

Services Provided Through Care Management
Home Delivered or Congregate Meals
Social Day Care
Social and Environmental Supports

*Medicare may cover these services based on certain criteria. If Medicare covers any of these services, then Medicare will be billed first. If you have additional insurance (other than Medicare or Medicaid) that covers any of the above services, this additional insurance will be billed before Integra. Please always show your Medicaid, Medicare, and Integra cards when obtaining care or services.

When utilizing any of the above services that are reimbursable by Medicare, you have the freedom to choose your own provider. However, you are encouraged to use Integra’s network providers.

Note that the covered services listed can also be delivered by telehealth. Telehealth provides services using electronic information or communications technologies when medically appropriate and when prior authorization for this method of providing care has been obtained.

Descriptions of Covered Services

Adult Day Health Care	Care provided in a residential health care facility that includes the following services: medical, nursing, food and nutrition, social services, rehabilitation therapy, planned leisure time activities, dental, and pharmaceutical services.
Audiology/Hearing Aids	Audiology services include hearing tests and the prescription of hearing aids. Hearing aid services include selecting, fitting and dispensing of hearing aids, as well as necessary maintenance and upkeep of the device. This category also includes the actual hearing aids and associated parts.
Care Management	Process that assists you in accessing necessary covered services as identified in your Person Centered Service Plan. Care management services include coordination of your services regardless of whether they are in the benefit package.
Consumer Directed Personal Assistance Services	Allows you to receive assistance with personal care services, home health aide services, and skilled nursing tasks from a consumer-directed personal assistant. Please see the “Consumer Directed Personal Assistance Service (CDPAS)” section for greater detail.

Dentistry	<p>Integra partners with HealthPlex to provide the following dental services: Diagnostic and Preventive Services, Restorative Dentistry, Root Canal Therapy*, Periodontics, Prosthetics-Crowns and Removable*, Prosthetics- Removable*, Emergency Dental Services*.</p> <p>(*Prior Authorization required or other limitations may apply.)</p>
Durable Medical Equipment (DME)	<p>This is equipment a health care practitioner has determined is necessary for the treatment of your medical condition. Examples include Medical/Surgical Supplies, Enteral and Parenteral Formula, and Hearing Aid Batteries. Prosthetics, Orthotics, and Orthopedic Footwear are not durable medical equipment.</p>
Home Care	<p>Services provided in your home, including nursing, home health aide services, medical social services, physical therapy, occupational therapy, and speech pathology therapy.</p>
Home Delivered or Congregate Meals	<p>Meals available for members who cannot prepare or obtain nutritionally adequate meals for themselves.</p>
Medical Social Services	<p>Services by a qualified social worker within the context of your plan of care with the goal of helping you stay in your home.</p>
Non-emergent Transportation	<p>Transportation related to a medical need that is not an emergency. Integra partners with LogistiCare to fulfill your non-emergent transportation needs.</p>
Nursing Home Care (Residential Health Care Facility)	<p>For those who require more care than can be provided in the home. Nursing Home Care is covered for individuals requiring either short-term care or permanent placement, provided they are eligible for institutional Medicaid coverage.</p>
Nutrition Services	<p>These are services provided by a qualified nutritionist such as the assessment of your nutritional needs, nutrition education, and the planning of your diet.</p>
Occupational Therapy	<p>Rehabilitation services provided by a licensed and registered occupational therapist to address a physical or mental disability and restore you to your best functional level.</p>
Optometry/Eyeglasses	<p>This includes services by an optometrist or an ophthalmic dispenser. Equipment covered by this category includes eyeglasses, medically necessary contact</p>

	lenses and polycarbonate lenses, artificial eyes, and low vision aids.
Personal Care	Assistance with activities such as personal hygiene, dressing, and eating.
Personal Emergency Response System	This is an electronic alarm device that allows you to more easily signal for help in the event of an emergency.
Podiatry	Medical services for your feet provided by a podiatrist.
Private Duty Nursing	Continuous care provided in your home by a registered professional or licensed practical nurse (RN or LPN).
Respiratory Therapy	Services by a qualified respiratory therapist to help with your breathing.
Social and environmental supports	Services such as home maintenance, cleaning, chores, home improvement, as well as respite care.
Social Day Care	Provides functionally impaired individuals with socialization, supervision, and nutrition in a protective setting during any part of the day, but for less than a twenty-four (24) hour period.
Speech Therapy	Treatment by a licensed and registered speech-language pathologist to assist with the rehabilitation of your speaking.
Telehealth	This is a different means of receiving your health services rather than a service. Telehealth makes use of electronic information and communication technologies to deliver or support your services at a distance. Examples of telehealth are health care via live video or e-mail, mobile health (mHealth), or remote patient monitoring (RPM).

Limitations on Covered Benefits

- Outpatient Physical Therapy, Occupational Therapy and Speech Therapy are limited to 20 Medicaid visits per year, per therapy (limitation does not apply to individuals with developmental disabilities).
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means and to the following conditions:

- Tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube;
 - Individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means;
 - Adults with a diagnosis of HIV infection, AIDS, HIV-related illness, or other disease or condition, who are oral-fed, and who require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, and have a body mass index (BMI) under 18.5 as defined by the Centers for Disease Control, up to 1,000 calories per day; or require supplemental nutrition, demonstrate documented compliance with an appropriate medical and nutritional plan of care, have a body mass index (BMI) under 22 as defined by the Centers for Disease Control, and a documented, unintentional weight loss of 5 percent or more within the previous 6 month period, up to 1,000 calories per day; or require total oral nutritional support, have a permanent structural limitation that prevents the chewing of food, and placement of a feeding tube is medically contraindicated.
- Nursing Home Care is covered for individuals requiring either short-term care, provided you are eligible for institutional Medicaid coverage.
 - Dental care provided through HealthPlex includes: Diagnostic and Preventive Services, Restorative Dentistry, Root Canal Therapy*, Periodontics, Prosthetics-Crowns and Removable*, Prosthetics-Removable*, Emergency Dental Services*. (**Prior Authorization required or other limitations may apply.*)

Services that an Integra member may require that are not covered by Integra but are billed directly by the Provider to Medicaid, Medicare, or other third party payer may be included in the member's Plan of Care and coordinated by the Care Management Team in collaboration with the member's primary

care physician and other providers involved in the member's care. Note that Integra is always the secondary payer to Medicare and other third party payers. For members with Medicare coverage, if a covered service is paid for by Medicare, Integra will pay the deductibles, copays, or coinsurances.

Services Not Covered by Integra, Medicare, or Medicaid

If medical services are not covered by Integra, Medicaid, or Medicare, you must pay for them 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 Integra or Medicaid are:

- Cosmetic surgery if not medically necessary;
- Personal and Comfort items;
- Infertility Treatment;
- Provider services that are not part of the plan (unless Integra sends you to that provider).

If you have any questions, call Member Services at 1-855-661-0002 (TDD/TTY: 711).

OBTAINING COVERED SERVICES

During the care planning process, your Care Management Team will work with you, your family/caregiver, and your health care providers to determine the services you require. Your Care Manager will then authorize the services you will receive from Integra, and your Service Coordinator will make referrals to participating Integra providers and arrange services for you. When a physician order is required, your Care Management Team will work with your physician and other providers to ensure that the proper order is obtained. We do the work for you to ensure that everything you need is in place.

Requesting Service Authorization

If you feel at any time you need a certain covered service, you or your provider on your behalf may request authorization for the service by making a verbal or written request to your Care Manager, by calling Member Services at 1-855-661-0002 (TDD/TTY: 711), or by sending the request in writing to:

Care Management
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042

Authorization is the process by which the requested service is determined to be medically necessary by Integra. Services will be authorized in a certain amount and for a specific period of time.

If you need to receive more of the care that you are currently receiving during an authorization period, you will need to obtain prior authorization. This is called **concurrent review**.

All covered services require prior authorization except for the following services which members can self-refer for evaluation or for routine services:

- Dental care – routine referrals and services covered under HealthPlex
- Vision care – routine vision exam and services covered under Davis Vision

After You Request Service Authorization

Integra's Care Management Team will review the request for service authorization to ensure that:

- It is medically necessary (that is, necessary to prevent, diagnose, correct, or cure conditions that cause acute suffering, endanger life, result in illness or infirmity, interfere with your capacity for normal activity, or threaten some significant handicap);

- It is reasonably expected to achieve its purpose;
- It will allow you to remain safely in your home.

Upon receiving your request, the Care Manager will reach out to you and your health care provider to discuss the circumstances under which the service authorization request is being made and gather all necessary information in order to determine whether the request should be handled within the standard timeframe or on an expedited timeframe. The review will follow an expedited timeframe if Integra believes that a delay in service authorization could be harmful to you.

You or your doctor may also request an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will inform you and then 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, and no later than as outlined in the timeframes below.

Timeframes for Integra’s Decision on Service Authorization Requests

Standard Review

A standard review decision will be made within three (3) work days of when we’ve received all necessary information relating to your request, and we will contact you regarding this decision no later than fourteen (14) days after your request is received. We will tell you by the third work day if we need more information.

Expedited Review

An expedited review decision will be made within one (1) work day of when we’ve received all necessary information relating to your request, and you will hear from us no later than three (3) days from when we receive your

request. We will tell you by the third work day if we need more information.

Timeframes for Concurrent Review Requests

When a request is made for an increase in the number or duration of service already being provided, the request is called a **Concurrent Review**.

Standard Review

We will make a decision within one (1) work day of when we have all the information we need, and you will hear from us no later than fourteen (14) days after we received your request.

Expedited Review

We will make a decision within one (1) work day of when we have all the information we need, and you will hear from us no later than three (3) work days after we received your request.

Timeframe for Services Following Inpatient Admission

If you request home health care services following an inpatient admission, the request shall be handled as expedited, and the determination shall be made within one (1) business day after receipt of necessary information, and no later than three (3) business days after receipt of the request.

Timeframes for Extensions

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

- Notify you in writing regarding the needed information. If your request is for an expedited review, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.

- Make a decision as quickly as we can when the necessary information is received, and no later than fourteen (14) days from the end of original timeframe.

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

You, or someone acting on your behalf, may also request we take more time to make a decision, perhaps because you have more information to provide us to help decide your case. This can be done by calling Member Services at 1-855-661-0002 (TDD/TTY: 711), or sending the request in writing to:

Care Management
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042

ADDRESSING YOUR PROBLEMS AND CONCERNS

Integra will try its best to resolve your concerns or issues as quickly as possible and to your satisfaction. You may use either our grievance process or our appeal process, depending on what kind of problem you have.

There will be no change in your services or the way you are treated by Integra staff or a health care provider due to your filing of a grievance or an appeal. We will also maintain your privacy and provide any help you may need to complete the filing. This includes providing you with interpreter services or assistance if you have vision and/or hearing problems. You may also choose someone (like a relative, friend, or a provider) to act for you.

To file a grievance or to appeal a plan action, please call: 1-855-661-0002 (TTY: 711) or write to:

Appeals and Grievances

Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042

When you contact us, you will need to give us your name, address, telephone number and the details of the problem.

What is a Grievance?

A grievance is any communication by you to us of dissatisfaction about the care and treatment you receive from our staff or providers of covered services. For example, if someone was rude to you or you do not like the quality of care or services you have received from us, you can file a grievance with us.

Grievance Process

A grievance may be filed orally or in writing. The person who receives your grievance will first record it, and then appropriate plan staff will oversee the review of the grievance. Integra will also send you a letter telling you that we received your grievance and a description of the review process. We will review your grievance and give you a written answer within one of two timeframes:

- If a delay would significantly increase the risk to your health, we will decide within forty-eight (48) hours after receipt of necessary information;
- For all other types of grievances, we will notify you of our decision within forty-five (45) days of receipt of necessary information, but the process must be completed within sixty (60) days of the receipt of the grievance. The review period can be increased up to fourteen (14) days if you request it or if we need more information and the delay is in your interest.

Our response will include a description of our findings and our decision regarding your grievance.

Appealing a Grievance Decision

If you are not satisfied with Integra's decision concerning your grievance, you may request a second review of your issue by filing a grievance appeal. This must be filed in writing and within sixty (60) business days of receipt of our initial decision about your grievance. Once Integra receives your appeal, we will send you a written acknowledgement telling you the name, address, and telephone number of the individual we have designated to respond to your appeal. All grievance appeals will be conducted by appropriate professionals, including health care professionals for grievances involving clinical matters, none of whom will have been involved in the initial decision.

For standard appeals, we will make the appeal decision within thirty (30) business days of receiving all necessary information to make our decision. If a delay in making our decision would significantly increase the risk to your health, we will use the expedited grievance appeal process. For expedited grievance appeals, we will make our appeal decision within two (2) business days of receipt of necessary information. For both standard and expedited grievance appeals, we will provide you with written notice of our decision. The notice will include the detailed reasons for our decision and, in cases involving clinical matters, the clinical rationale for our decision.

ACTIONS AND APPEAL OF ACTIONS

What is an Action?

Any one of the following carried out by Integra constitutes an action:

- A denial or limited authorization of a requested service;

- A restriction, reduction, suspension, or termination of a previously covered service;
- Denial of payment for services, either in whole or in part;
- Failure to provide timely services;
- Determination that a requested service is not a covered benefit;
- Failure to make grievance, appeal, and grievance appeal determinations and notifications within the required timeframes.

An action is subject to appeal. (See “How do I File an Appeal of an Action?” below for more information.)

Timing of Notice of Action

If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to restrict, reduce, suspend or terminate a service that is authorized, our letter will be sent at least ten (10) days before we intend to change the service.

Contents of Notice of Action

Any notice we send to you about an action will:

- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State’s external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision (if the action involved issues of medical necessity or whether the treatment or service in question was experimental or

investigational);

- Describe the information, if any, which must be provided by you and/or your provider in order for us to render a decision on appeal.

The notice will also tell you about your right to a State Fair Hearing:

- It will explain the difference between an appeal and a Fair Hearing;
- It will say that that you do not have to file an appeal before asking for a Fair Hearing;
- It will explain how to ask for a Fair Hearing; and
- If we are restricting, reducing, suspending, or terminating an authorized service and you want your services to continue while your appeal is decided, you must ask for a Fair Hearing within ten (10) days of the date on the notice or the intended effective date of the proposed action, whichever is later;
- It will explain that Integra will not act in any manner as to restrict your right to a fair hearing or to influence your decision to pursue a fair hearing.

How do I file an Appeal of an Action?

If you do not agree with an action that Integra has taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within sixty (60) business days of the date on our letter notifying you of the action.

How do I Contact my Plan to file an Appeal?

We can be reached at 1-855-661-0002 (TTY: 711), or by writing to:

Integra MLTC
Appeals and Grievances
1981 Marcus Avenue, Suite 100

The person who receives your appeal will record it, and then appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff members who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service during the Appeal Process

If you are appealing a restriction, reduction, suspension, or termination of services you are currently authorized to receive, you must request a Fair Hearing to continue to receive these services while your appeal is decided. We must continue your service if you ask for a Fair Hearing no later than ten (10) days from the date on the notice about the restriction, reduction, suspension, or termination of services, or the intended effective date of the proposed action, whichever is later. To find out how to ask for a Fair Hearing and to ask for aid to continue, see the Fair Hearing Section below.

Although you may request a continuation of services, we may require you to pay for these services if the Fair Hearing is not decided in your favor, but only if they were provided solely because you asked to continue to receive them while your case was being reviewed.

How Long Will it Take Integra to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, and no later than thirty (30) days from the day we receive an appeal. (The review period can be increased up to fourteen (14) days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will also send you a notice regarding the decision we've made about your appeal. It will identify the decision we made and the date we reached that decision.

If we reverse our decision to deny or limit requested services, or reduce, suspend, or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

If you or your provider feels that taking the time for a standard appeal could result in a serious risk to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within two (2) business days after we receive all necessary information. In no event will the time for issuing our decision be more than three (3) business days after we receive your appeal. (The review period can be increased up to fourteen (14) days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best effort to contact you in person to inform you of our decision and of our intent to handle your appeal as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two (2) days of receiving your request.

If you had an expedited action appeal and are not satisfied with our decision, you can choose to file a standard action appeal with us or ask for an external appeal. If you choose to file a standard action appeal with us, and we uphold our decision, you will receive a new final determination and again have the opportunity to ask for an external appeal.

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within two (2) business days after we receive all necessary information. In

no event will the time for issuing our decision be more than three (3) business days after we receive your appeal. (The review period can be increased up to fourteen (14) days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within two (2) days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and, for some appeals, your right to request to receive services while the Hearing is pending and how to make the request.

Notice that you must request a Fair Hearing within sixty (60) calendar days after the date on the Initial Determination Notice. This deadline applies even if you are waiting for us to make a decision on your Internal Appeal.

If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an “external appeal” of our decision.

State Fair Hearings

You may also request a Fair Hearing from New York State. The Fair Hearing decision can overrule our original decision, whether or not you asked us for an appeal. You must request a Fair Hearing within sixty (60) calendar days of the date we sent you the notice about our original decision. You can pursue a Plan appeal and a Fair Hearing at the same time, or you can wait until the Plan decides your appeal and then ask for a Fair Hearing. In either case, the same sixty (60) calendar day deadline

applies.

The State Fair Hearing process is the only process that allows your services to continue while you are waiting for your case to be decided. If we send you a notice about restricting, reducing, suspending, or terminating services you are authorized to receive, and you want your services to continue, you must request a Fair Hearing. Filing an internal or external appeal will not guarantee that your services will continue.

To make sure that your services continue pending the appeal, generally you must request the Fair Hearing AND make it clear that you want your services to continue. Some forms may automatically do this for you, but not all of them, so please read the form carefully. In all cases, you must make your request within ten (10) days of the date on the notice, or by the intended effective date of our action (whichever is later).

Your benefits will continue until you withdraw the appeal, the original authorization period for your services ends, or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we are required to ensure that you receive the disputed services promptly and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer.

Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

You can file a State Fair Hearing by contacting the Office of Temporary and Disability Assistance:

Online Request Form

<https://errswebnet.otda.ny.gov/errswebnet/erequestform.aspx>

Mail a Printable Request Form

NYS Office of Temporary and Disability Assistance
Office of Administrative Hearings
Managed Care Hearing Unit
P.O. Box 22023
Albany, New York 12201-2023

Fax a Printable Request Form

(518) 473-6735

Request by Telephone

Standard Fair Hearing line: 1-800-342-3334
Emergency Fair Hearing line: 1-800-205-0110
TTY line: 711 (request that the operator call 1-877-502-6155)

Request in Person

New York City
14 Boerum Place, 1st Floor
Brooklyn, New York 11201

Albany
40 North Pearl Street, 15th Floor
Albany, New York 12243

For more information on how to request a Fair Hearing, please visit:
<http://otda.ny.gov/hearings/request/>

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental/ investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State, but who are qualified and approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental/ investigational, we will provide you with information about how to file an external appeal, including

a form on which to file the external appeal. If you want the external appeal, you must file the form with the New York State Department of Financial Services within four (4) months from the date we denied your appeal.

Your external appeal will be decided within thirty (30) days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will then tell you and us of the final decision within two (2) business days of the decision being made.

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

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the “one that counts.”

ACCESS TO PROVIDERS

Transitional Care

If you are transitioning from a Medicaid fee-for-service community based long term care program, Integra will continue to provide services authorized under your pre-existing service plan and allow you to keep your service providers for a minimum of ninety (90) days. Non-network providers may continue to render the services during this transitional period so long as they accept payment rate offered by Integra, adhere to Integra's quality assurance and other policies, and provide medical information about the care to Integra.

If Integra terminates, reduces, suspends, or otherwise restricts access to these pre-existing services, you will receive an official notification from Integra and will have the right to a fair hearing and external appeal, as well as the right to have the disputed services continued while the request is processed (see "State Fair Hearings" and "State External Appeals" in "Actions and Appeals of Actions" section).

Participating Providers in Integra's Network

Covered services are delivered by a network of participating providers. This network is designed to ensure you have adequate choice to meet any special needs you may have. Additionally, all of our providers have contracted with Integra to ensure quality care for Integra's members. Please refer to the Integra Provider Directory for a listing of all participating network providers. You may also contact Member Services if you need another copy of the Directory, or you may access it on our website at www.integraplans.org. You have the right to select any of the providers participating in Integra's network, and if you find the selection process at all difficult, your Care Management Team is glad to assist you. The Team's analysis will take into account factors such as the languages you are fluent

in, disabilities and special needs you may have, as well as your personal preferences.

We want you to be fully satisfied with all of your service providers. If you are unhappy with one for any reason, you can switch to another participating network provider. Assistance is available from your Care Management Team.

Payment to our network providers will be made by Integra for each authorized service they provide you. There is no cost to you. Contact your Care Manager if you receive a bill from a provider for any covered services authorized by Integra, as you are not responsible for it. However, you may be responsible for payment of covered services that were **not** authorized by Integra or for covered services that are obtained from providers **outside** of Integra's network.

Any services you currently receive that are covered by Medicaid or Medicare that are not covered by Integra will continue to be covered by Medicare and/or Medicaid fee-for-service. Therefore, it is important for you to carry you Medicare and Medicaid cards in addition to your Integra ID card.

Veterans' Homes

An Integra member who is a veteran, the spouse of a veteran, or a Gold Star parent, can access the services of a veterans' home in the network. If there is a veteran's home that is not contracted in the network, but is located in the Integra service area, arrangements can be made to allow an eligible member to access its services. Consult your Care Manager if you are both eligible and interested.

Dental Provider

Integra partners with HealthPlex to administer dental benefits for our members. As an Integra member, you may access dental services directly without a referral through HealthPlex's contracted dental providers. Upon

enrollment with Integra, you will be assigned a Primary Care Dentist who is close to your home. If you wish to change your dentist, call HealthPlex at 1-800-468-9868 (TTY/TDD: 711) for assistance.

Vision Provider

Integra partners with DavisVision to administer the vision benefits for our members. As an Integra member, you may access vision services directly without a referral through DavisVision's contracted providers.

Transportation Provider

Integra partners with LogistiCare to administer the non-emergent transportation benefit to our members. As an Integra member, you may access non-emergent transportation services through a LogistiCare contracted transportation vendor. You must provide at least three (3) days' notice for any transportation requests and ten (10) days if you would like to use the MetroCard option for the bus or subway.

To schedule non-emergent transportation:

Call LogistiCare: 1-877-831-3146

"Where's My Ride" line: 1-877-831-3147 (TTY/TDD: 1-866-288-3133)

Out-of-Network Care

If you require a covered service from a non-participating provider, Integra will authorize such service to be provided out-of-network. Such out-of-network authorization will be provided until the services can be provided in-network. One-time authorization may be provided for services such as durable medical equipment, orthotics, prosthetics, or home repair. For services that require continued care such as home health care or personal care, authorization will be granted a maximum of ninety (90) days at a time.

Time outside the Service Area

If you plan to be out of the service area for more than thirty (30) consecutive days, Integra is required to initiate involuntary disenrollment, as we will not be able to effectively monitor and administer your plan of care. Please contact your Care Manager to discuss your options and to plan transition of your care.

Emergency Care

An emergency is an acute injury or illness that poses an immediate risk to a person's life or long-term health. In the event of any emergency, you should seek immediate care in an emergency room or call 911.

You are not required to obtain prior authorization from Integra for emergency care, nor do covered services that are medically necessary to stabilize or treat an emergency condition require prior authorization. But in the event of an emergency, you or someone on your behalf should contact your Care Manager as soon as possible, and no later than three (3) days after the emergency.

Your Care Manager will inquire as to the circumstances of your emergency, obtain information from the emergency facility, and determine what additional services, if any, you might need to stabilize your care or prevent similar emergencies in the future. If an adjustment to services is appropriate, your care plan will be revised accordingly.

When Integra is arranging covered services in an emergency, authorization of service provisions will be for a period of three (3) days. An authorization request must be made in order for the service to continue past three (3) days unless the Care Manager deems continued service medically necessary. If a service is requested by or on behalf of a member during an emergency and there appear to be grounds for urgency, the request will be handled as an expedited request.

Hospitalization

In the event of a hospitalization, you or someone on your behalf should contact Integra as soon as possible, and no later than twenty-four (24) hours after admission. Your Care Manager will cancel or postpone your regularly scheduled services and appointments for the duration of your hospital stay.

Prior to discharge, be sure to ask your hospital discharge planner to contact your Care Manager to schedule the resumption of your previous benefits and services, and arrange for any new benefits and services you may need upon discharge.

Medicare Covered Services

Membership with Integra does not affect your Medicare coverage. Your Medicare covered services will continue to be covered by Medicare, and if you are enrolled with a Medicare Advantage Plan, by that plan. You do NOT need to change your health care provider or Medicare Advantage Plan if you are enrolled in one. For Medicare services, you do not have to utilize an Integra participating provider; you may choose any provider you wish. You do not need to obtain approval from Integra to receive any Medicare covered benefits. Once your Medicare coverage is exhausted, or a service is NOT covered by Medicare, Integra will then become the primary carrier for any plan-approved benefits and you will need to switch to one of our participating providers for that service.

Integra can assist you with coordination of Medicare services by:

- Arranging Medicare covered home health services;
- Arranging non-emergency transportation;
- Scheduling appointments for lab work, x-rays, or any other diagnostic tests or services approved by your physician.

If you receive benefits or services that are covered both by Medicare and Integra, Medicare will always be the primary insurance. If Medicare does not

cover the entire cost of these services, Integra may be billed for co-insurance and deductibles.

If you are currently receiving Medicare-covered services or benefits, you may continue to use your current provider for those services. We do, however, recommend that you consider using an Integra participating provider. This will ensure your services remain covered in the event that Medicare limits or ends your coverage. If your current provider is not an Integra participating provider, contact your Care Management Team to discuss your options.

DIENROLLMENT FROM INTEGRA

Voluntary Disenrollment

You may disenroll from the Integra MLTC program at any time and for any reason by oral or written notification to Integra. If you choose to voluntarily disenroll but do not choose to enroll with another MLTC Plan, another type of managed care plan, or a waiver program, you may no longer be able to receive community-based services, such as personal care.

An Integra representative will ask your reason for disenrollment in order to determine if there is a problem that might be addressed. If you still choose to disenroll, we will send you a confirmation letter acknowledging the receipt of your request for disenrollment. We will also ask you to sign a voluntary disenrollment form. If you are unable or unwilling to sign this, we will proceed with your disenrollment. Integra will then transmit the disenrollment request with your pertinent information to New York Medicaid Choice (NYMC) or the LDSS for its review and approval.

You should be aware that disenrollment is not immediate. It could take up to six (6) weeks to process, depending on when your request is received. The effective date of your disenrollment will thus be approximately two (2) months after the disenrollment was requested.

During the disenrollment process, Integra will continue to arrange managed long term care services for you and also coordinate the transfer of your care to the provider you indicate will care for you after your disenrollment.

You have the option of remaining with Integra if you need hospice care. However, if you disenroll to enter a hospice, Integra will continue to provide, for the month following the admission, those services deemed medically necessary if they cannot be obtained from the new program.

Involuntary Disenrollment

Integra must obtain authorization from the LDSS to disenroll you involuntarily, and you will not be involuntarily disenrolled on the basis of adverse change in health status, your need for covered services, or the cost of your covered services.

Integra will initiate involuntary disenrollment if it has been confirmed that:

- You permanently move out of Integra's service area;
- You are out of the service area for more than thirty (30) consecutive days;
- You are no longer eligible for Medicaid benefits;
- You need nursing home care, but are not eligible for institutional Medicaid;
- You no longer demonstrate a clinical or functional need for community-based long term care services, or, if you are a non-dual eligible enrollee, you no longer demonstrate a clinical or functional need for community-based services AND no longer meet the nursing home level of care;
- Your sole service is Social Day Care;
- You are hospitalized for a period of forty-five (45) consecutive days or longer;
- You become a resident in a facility that is under the auspices of the Offices of Mental Health (OMH), Persons with Developmental

Disabilities (OPWDD), or Alcoholism and Substance Abuse Services (OASAS);

- You are incarcerated.

Integra will also initiate disenrollment in the following situations if, after several attempts to work with you and/or your representative, we determine that the problem cannot be effectively resolved:

- You or your family, or other persons in your home engage in conduct or behavior that prevents Integra from providing the care you need (not including behaviors that result from your special needs);
- You knowingly provide false information or behave in a deceptive or fraudulent way;
- You or your family member fails to complete or submit any consent form or other document that is needed to obtain services for you;
- Your physician refuses to collaborate with Integra or staff in developing and implementing a plan of care for you. “Physician collaboration” means the willingness to utilize network providers and write orders for covered services;
- You fail to pay for or make arrangements for the payment of, any spend-down or surplus amount owed to Integra as determined by the LDSS within thirty (30) days after such amount first becomes due, so long as Integra makes a reasonable effort to collect beforehand, including making a written demand for payment.

For any involuntary disenrollment, Integra will notify you in writing that it has initiated the disenrollment process and provide the reason for such action. Involuntarily disenrolled members will be notified of their appeal rights by the LDSS.

Upon receipt of an approval for disenrollment, Integra will send a letter to you confirming disenrollment. This letter will state the disenrollment effective date, which will be the first day of the month following the month in

which the disenrollment is processed through eMedNY. Integra will continue to provide and arrange for covered services until the effective date of disenrollment and make all necessary referrals for alternative services.

Integra will not disenroll a member based upon an adverse change in the member's health or due to changes in the capitation rate payable to Integra. Disenrollment will never be initiated as a result of the member's utilization of covered services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

Re-enrollment with Integra

If you voluntarily disenroll, you will be allowed to re-enroll in the program if you meet our eligibility criteria for enrollment. If you are involuntarily disenrolled, you will be allowed to re-enroll in the program if the circumstances that were the basis for disenrollment have been resolved.

If you were involuntarily disenrolled due to your failure to make payment of spend-down, you will need to make a full payment of balance due before you can re-enroll with Integra.

All re-enrollments are required to be handled as if they were new enrollments. As such, Integra must re-establish your eligibility for enrollment and conduct a home visit to complete assessments and enrollment application.

MISCELLANEOUS

Consumer Directed Personal Assistance Services (CDPAS)

Through the Consumer Directed Personal Assistance Service (CDPAS) Program, members can receive partial or total assistance with personal care tasks, home health aide tasks, and/or skilled nursing tasks. The CDPAS

assistant performing these tasks is directed, instructed, and supervised by the member. This allows chronically ill and/or physically disabled members greater flexibility and freedom of choice in receiving their home care services. You may exercise the CDPAS option any time during the course of your enrollment with Integra.

If you opt to use CDPAS, Integra will continue to be responsible for comprehensive assessment and development of a person centered service plan. However, we will permit you (or your representative) to have decision making authority regarding CDPAS staff with respect to recruitment, training, scheduling, evaluation, time sheet verification and approval, and discharge.

To participate in the CDPAS Program, you must obtain a valid Physician's Order and meet all of the following eligibility requirements:

- Have a stable medical condition;
- Be self-directing or, if not self-directing, have a designated representative;
- Need some or total assistance with one or more personal care tasks, home health aide tasks, or skilled nursing tasks;
- Be willing and able to fulfill CDPAS responsibilities (outlined below) or have a designated representative who is willing and able to fulfill such responsibilities; and
- Participate as needed or have a designated representative who participates as needed, in the required assessment and reassessment processes.

Prior to receiving CDPAS, you must sign a consumer acknowledgement of the roles and responsibilities of Integra and the member which are as follows:

Integra's CDPAS Responsibilities

- Provide you with information on how to qualify for CDPAS and other community-based long term care services;

- If you express interest in CDPAS, to provide you with written educational materials outlining the details and associated responsibilities you or your designated representative would need to undertake;
- Assess whether you are eligible to receive home care or personal care services;
- Determine if you or a designated representative are able and willing to assume all responsibilities associated with receiving CDPAS;
- Determine whether you are eligible to receive CDPAS;
- Assess your health and document it in the patient centered care plan to ensure adequate supports are available to meet your needs;
- Authorize the type, amount, and level of services you require;
- Develop a plan of care with you, outlining the tasks to be completed by the personal assistant. The plan of care document will be maintained by Integra and a copy will be provided to you;
- If it is determined that you are no longer eligible to continue receiving CDPAS or if Integra terminates your receipt of CDPAS, Integra will assess on an ongoing basis whether you require personal care, home health care, or some other level of service;
- Provide you with appropriate notices in the event of any termination or reduction in the level and amount of services, including a notice of fair hearing, and, additionally, to provide you with appropriate notice if it is determined that you are ineligible or no longer eligible to receive CDPAS.

You or Your Designated Representative's CDPAS Responsibilities

- Review the information provided by Integra about CDPAS and understand the roles and responsibilities of Integra, the fiscal intermediary, and you;
- Be responsible for recruiting, hiring, training, supervising, scheduling, and terminating the personal assistant(s) of your choosing in order to better meet your needs;

- Maintain an appropriate home environment for the safe delivery of care;
- Train the personal assistant(s) to implement the plan of care;
- Comply with labor laws, providing equal employment opportunities as specified in the agreement between you and the Fiscal Intermediary (FI);
- Inform Integra and the FI of any change in status or condition, including, but not limited to: hospitalizations, address and telephone number changes, vacations within five (5) business days;
- Assure the accurate and timely submission of the personal assistant's required paper work to the FI, including time sheets, annual worker health assessments, and required employment documents;
- Develop and maintain a contingency plan to ensure adequate supports are available to meet your needs;
- Review and sign the personal assistant's weekly timecard to ensure the timecard reflects the actual number of authorized hours worked;
- Cooperate with Integra and agree to comply with Medicaid Managed Care Program requirements, including, but not limited to, availability for required reassessments;
- Report and return to Integra any overpayment or inappropriate payments from the Medicaid program made to Consumer Directed Personal Assistants.

If you desire, you may terminate CDPAS and receive Personal Care services through an Integra network provider. You also may be involuntarily disenrolled from CDPAS if:

- Continued participation in CDPAS would not permit your health, safety, or welfare needs to be met;
- You demonstrate an inability to carry out the required tasks for CDPAS;
- There is evidence of fraudulent use of Medicaid funds in relation to your participation in CDPAS, such as an indication that CDPAS documents have been falsified.

Integra will review your ongoing eligibility for CDPAS during its semi-annual reassessment and care plan update process. This involves the evaluation of whether you (or your designated representative) have satisfactorily fulfilled the consumer's responsibilities under the CDPAS. If Integra determines that you are no longer eligible for CDPAS, Integra will send you (or your designated representative), a timely and adequate notice of our intent to discontinue your participation.

Any restriction, reduction, suspension, or termination of authorized CDPAS services or a denial of any request to change CDPAS participation status is considered an adverse determination by Integra. This means you may request a fair hearing or external appeal upon the final adverse determination.

Advance Directives

You have a right to make your own health care decisions. If this becomes impossible due to an accident or illness, you can still have your decisions exercised so long as you prepare advance directives. Advance directives are documents that establish your desired health care decisions in the event you are unable to speak for yourself.

There are several types of advance directives:

Health Care Proxy

Execution of this document appoints a trusted person (a “proxy”) to make health care decisions on your behalf should you be unable to do so.

Do Not Resuscitate Order

You have the right to decide if you want emergency treatment such as cardiopulmonary resuscitation (CPR) in the event your breathing or heart stops. If you do not want such treatment, you can make your wishes

known in writing through a Do Not Resuscitate (DNR) form. Your Primary Care Physician will then add a DNR to your medical records at your request. You can also get a copy of the DNR form to carry on your person and/or a DNR bracelet that will help ensure emergency health care providers are aware of your wishes.

Organ Donor Card

This wallet-sized card establishes that you are willing to donate parts of your body to help others when you die. You can also complete the organ donor information on the back of your New York State driver's license or non-driver identification card in order to let others know if and how you would like to donate your organs.

Living Will

A living will allows you to provide specific written instructions regarding your health care decision wishes should you become incapacitated.

It is your choice as to whether you wish to complete an advance directive and to determine which type(s) are best for you. You may execute any, all, or none of the advance directives listed above. Note that the law forbids any discrimination in providing you medical care based on whether you have an advance directive or not.

For more information regarding advance directives, please speak with your Care Manager or your Primary Care Physician. Integra's enrollment packet contains forms for the advance directives detailed above. If you need additional forms, Integra will provide those for you. Consulting a lawyer is not required to execute an advance directive, but you may wish to do so considering the importance of these documents. You can always revise or cancel advance directives at any time should you change your mind. Contact your Care Manager to make any changes.

Fraud & Abuse

To demonstrate Integra is committed to preventing and detecting any fraud and abuse activities by members, providers, or staff, Integra has adopted a “zero tolerance” policy toward fraud and abuse.

If you know or suspect someone is misusing the Medicare or Medicaid program through fraud, abuse, or overpayment, file a report by writing or calling the Fraud & Abuse Investigation Department:

Integra MLTC
Fraud & Abuse Investigations
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042
1-855-420-0760

Fraud or misconduct related to the Medicare program will be reported to the Department of Health and Human Services, Office of the Inspector General (HHS-OIG). In the case of suspected fraud or misconduct related to the Medicare Prescription Drug Program, Integra will file a report with the Medicare Drug Integrity Contractor (MEDIC). Potential fraud, waste, and abuse related to Medicaid and other New York State funded programs will be reported to the State Department of Health (SDOH) and/or the Office of the Medicaid Inspector General (OMIG).

All reports filed by you or another on your behalf will be treated confidentially.

Integra Company Information You May Request

The following information is available to you upon request:

- Information on Integra’s structure and operations;

- A list of names, business addresses, and official positions of the membership of the board of directors, officers, controlling persons, owners, and partners of Integra;
- A copy of Integra's most recent annual certified financial statement, including a balance sheet and a summary of receipts and disbursements prepared by a CPA;
- Procedures for protecting the confidentiality of medical records and other enrollee information;
- A written description of the organizational arrangements and ongoing procedures of the quality assurance and improvement program;
- A description of procedures followed by Integra in making decisions regarding experimental or investigational drugs, medical devices, or any other treatments in clinical trial;
- Integra's clinical review criteria regarding particular conditions or diseases and, where appropriate, other clinical information Integra might consider in its utilization review process;
- Written application procedures and minimum qualification requirements for health care providers.

If you are interested in obtaining any one or more of the above items, contact Member Services at 1-855-661-0002 (TTY: 711).

Non-Discrimination Statement

Integra MLTC, Inc. ("Integra") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age, or disability. Integra does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Integra provides the following:

- 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); and

- Free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, call Integra at 1-855-661-0002 (TTY/TDD: 711)

If you believe that Integra has not provided you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Integra by:

- Mail: Appeals and Grievance Manager
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042
- Phone: 1-855-661-0002 (TTY/TDD: 711) Monday through Friday
8:00 AM to 5:00 PM.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web: Office for Civil Rights Complaint Portal at available at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
- Mail: U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>
- Phone: 1-800-868-1019 (TTY/TDD: 1-800-537-7697)

Multi-Language Interpreter Services

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-855-661-0002 (TTY/TDD: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-661-0002 (TTY/TDD: 711).

注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-661-0002 (TTY/TDD: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-661-0002 (رقم هاتف الصم والبكم).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-661-0002 (TTY/TDD: 711) 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-661-0002 (телетайп: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-661-0002 (TTY/TDD: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-661-0002 (ATS: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-661-0002 (TTY/TDD: 711).

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פון אפצאל. רופט 1-855-661-0002 (TTY/TDD: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-661-0002 (TTY/TDD: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-661-0002 (TTY/TDD: 711).

লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন 1-855-661-0002 (TTY/TDD: 711)।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-661-0002 (TTY/TDD: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-661-0002 (TTY/TDD: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔
کال کریں (TTY: 711) 1-855-661-0002

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PLEASE CONTACT INTEGRA'S MEMBER SERVICES DEPARTMENT AT 1-855-661-0002 (TTY: 711) IF YOU HAVE ANY QUESTIONS.

You have the right to receive a paper copy of this Notice of Privacy Practices at any time. You may request a paper copy even if you have previously received one, or received this Notice of Privacy Practices electronically. You may also print out a copy of this Notice of Privacy Practices by going to the Integra website at www.integraplan.org.

Integra is required to protect the privacy of your medical and personal information. Your medical and personal information is obtained in the course of providing services to you. This includes information such as your medical records, visits to your providers and information related to the payment of claims. Integra is required to give you this notice about how Integra uses (“discloses”) your medical and personal information. Integra will not disclose

any medical or personal information unless such disclosure is allowed or required by law, or you provide us with a written authorization allowing us to disclose your medical or personal information. If after reading this Notice of Privacy Practices, you have additional questions you can call Integra at **1-855-661-0002 (TTY/TDD: 711)** or write to Integra at:

Member Services
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042

How Does Integra Use Your Personal and Medical Information

The law allows Integra to disclose medical and personal information ***without*** a signed authorization from you when we are using the information to provide you with health benefits. Integra staff and those organizations that we contract with in order to provide you with health benefits are required to comply with Integra's requirements to protect the confidentiality of your medical and personal information.

As part of providing services to you, Integra may obtain personal, non-medical information about you such as your social security number, your address and your telephone number. Or, you may provide us with personal information when you contact Integra to ask a question or share a concern with us. Integra does not give out your personal information unless it is required or permitted by law. Unless you give us your permission, Integra will not give out your personal information for any purpose not related to your care.

Generally, Integra may use your medical information for payment, treatment, or healthcare operations. Below are some examples of what this means.

Payment: Your medical information may be disclosed for payment purposes. For example, when Integra determines your eligibility for a requested service, reimburses a provider that has treated you, or obtains payment from another insurance provider that is responsible for your coverage.

Treatment: Your medical information may be disclosed for treatment purposes. When you are seen by a provider in the Integra Provider Network,

or are seen by any other provider, hospital, nursing home or facility, those entities may share information about you in order to coordinate your care and provide you with treatment. For example, your Integra Care Manager may discuss your care with one of your providers or with a hospital in order to coordinate your care. The provider and hospital may also share your medical information in order to coordinate your care and provide you with treatment.

Health Care Operations: Your medical information may be disclosed for purposes of health care operations. This includes things like care management, utilization review, and quality improvement activities. We may also use your medical information to evaluate our own performance, do internal audits of our activities, and resolve any grievances that you may have. Your medical information may also be used to communicate with other health plans and providers in performing quality assurance, reviewing the competence and qualifications of your providers and conducting fraud, abuse and compliance activities.

Integra may use your medical information for other uses including:

Business Associates: Integra may also use or disclose certain medical information to business associates who perform certain activities on our behalf. This might include an entity that manages vision or dental benefits, Integra's attorney and accountants, or any other business associate who needs information in order to complete work delegated by Integra.

Health Oversight Activities: Integra may also disclose certain medical information to a variety of government or regulatory authorities. For example, we may disclose your medical information to the Department of Health for purposes of an audit, investigation, disciplinary action, or legal action. We may also need to report your medical information for a public health purpose, such as reporting the outbreak of a disease. We are required to share your medical information with the Secretary of the United States Department of Health and Human Services when the Secretary investigates whether Integra is complying with the HIPAA Privacy Regulations.

People Involved with Your Care: Integra may share your medical information with a family member, other relative, close friend or other personal

representative that you choose. This will be partly based upon how involved the person is with your care. We may share information with parents or guardians if allowed by law.

Law Enforcement: Integra may disclose your medical information if a law enforcement official asks us to. This may be done to help identify or locate a suspect or a missing person, or to provide information about the victim of a crime. We may also disclose your medical information if we receive a subpoena, a discovery request, or other court or legal order. We may also disclose your medical information in order to avoid a serious threat to your health or safety.

Coroners, Medical Examiners, Funeral Directors and Organ Donation. Integra may disclose your medical information to identify a deceased person, determine a cause of death, or to help the coroner or medical examiner in other ways, as allowed by law. We may also share your medical information with funeral directors, as allowed by law. We may also share your medical information with organizations that handle organ, eye or tissue donations or transplants.

There are a variety of other reasons that we may use your personal or medical information, including:

- Contacting you to remind you of an appointment
- Contacting you to see if you are interested in a disease management program
- Contacting you about a change in your benefits

Rights Related to Your Medical Information

Integra may not use or disclose your personal or health information without your permission if it is not the type of disclosure listed in this notice. You have the following rights:

- Right to Access Your Record: You can ask for your medical information by writing to Integra, or by calling Integra to request a release form for this purpose. Your request should describe the specific information that you want to review. There may be certain

information that we cannot provide such as psychotherapy notes, or information collected in anticipation of a claim or legal proceeding.

- Right to Amend/Correct: You can ask Integra to change your medical information if you can show that it is wrong, or that information is missing. In order to do this, you must send your request in writing or call Integra to request a form to change your medical record. If we do not believe that the changes that you have requested are appropriate, we will notify you in writing of how you can object to that decision, and how that objection will be included in your records.
- Right to Information About Who Accessed Your PHI: You can get a list of who received your medical information over a specific time period, which cannot be longer than the prior 6 years. This list will not include disclosures that were made for purposes of payment, treatment or operations, or disclosures that you authorized in writing. The first time that you request a list of disclosures in any 12-month period, we will provide it to you for free. If you request additional lists of disclosures during that 12-month period, we may charge you a fee to cover our costs in providing the additional lists.
- Right to Request Restriction: You can request restrictions on the way in which Integra uses or discloses your medical information to treatment, payment and health care operations. We may not agree with the restrictions that you request.
- Right to Request Special Handling of Communications: You have the right to ask Integra to send information to you in another way, or at a different address or location, if you believe that you may be endangered by Integra's usual form of communicating with you. If you make this request, you must state that you are asking for the change because you feel endangered, but you do not have to explain why you feel endangered. If you make this request, you must specify where or how you want to receive information, and/or how we should contact you to discuss. Integra will attempt to help you with all reasonable requests.
- Right to Designate a Personal Representative and Grant Access to Your PHI: You have the right to designate a representative to act on your behalf and ask Integra to provide to this designee a full access to all of your records. If you would like someone to act as your personal

representative, you must complete and return a Personal Representative Request Form to Integra. You may obtain this form by contacting your care manager or Member Services.

- **Right to Cancel Previous Authorization:** You have the right to cancel previous authorization for use or disclosure of your protected health information. We must have your written permission/authorization to use or share your information for any reason other than for reasons provided above (payment, health care operations, etc.). Generally, we ask you to grant this authorization at the time of your enrollment and the proof of your authorization is kept on file as part of your record. You may have also authorized Integra to share your health information with your personal representative. If at any point you change your mind and want to cancel your authorization or restrict the type of information we can share, you have the right to do so by so indicating in writing.

Complaints Regarding Your Privacy Rights

You may file a complaint with Integra, or with the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be discriminated against, penalized or retaliated against by Integra if you file a complaint. If you want to file a complaint with Integra, submit your complaint in writing to:

Grievances Unit
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, NY 11042

Or, you may submit a complaint to the Secretary of the United States Department of Health and Human Services at:

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza, Suite 3312
New York, NY 10278

Changes to the Notice of Privacy Practices

Integra may make changes to this Notice of Privacy Practices. We will promptly revise and distribute this Notice of Privacy Practices whenever we make a material change to the uses or disclosures allowed in this notice, a material change to your individual rights, a material change in our legal duties, or a material change in any other privacy practice contained in this notice. The most current notice will be made available on Integra's website at www.integraplan.org as soon as it is available. We will always distribute notice of any material change within 60 days of any material change. If we change the Notice of Privacy Practices, the new terms will apply to all of your medical and personal information, whether we received it before or after such changes.

Effective Date

This Notice of Privacy Practices is effective as of April 1, 2012.

IMPORTANT CONTACT INFORMATION

For Medical Emergency, Call 911

Integra

TTY/TDD Service	711
Member Services	1- 855- 661- 0002
Appeals	1- 347- 505- 3425
Grievances	1- 347- 505- 3426

DavisVision (Vision Services)

DavisVision Member Services	1- 800- 999- 5431
DavisVision Member Services TTY	711

HealthPlex (Dental Services)

HealthPlex Member Services	1- 800- 468- 9868
HealthPlex Member Services TTY	711

LogistiCare (Transportation Services)

LogistiCare Customer Service 3146	1- 877- 831-
“Where’s My Ride” Line 3147	1- 877- 831-
TTY Service 3133	1-866 -288-

Other Resources

NYS Managed Long-Term Care Complaint Hotline	1- 866- 712- 7197
NYS Fair Hearing Section, NYS OTDA	1- 800- 342- 3334
Department of Financial Services State External Appeals	1- 800- 400- 8882

