Medicaid Advantage Plus
2022 Member Handbook

RiverSpring MAP
(HMO D-SNP)

For more information, call us at:
1-800-362-2266 (**TTY 711**)
www.RiverSpringMAP.org

Welcome to RiverSpring MAP, a Medicaid Advantage Plus Program

Welcome to RiverSpring MAP (HMO D-SNP) Medicaid Advantage Plus Program. The RiverSpring MAP Medicaid Advantage Plus Program is especially designed for people who have Medicare and Medicaid and who need health and long-term care services like home care and personal care to stay in their homes and communities as long as possible.

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

HELP FROM MEMBER SERVICES

You can call us any time at the Member Services number below.

There is someone to help you at Member Services:
Monday through Sunday
8am to 8 pm ET
Call 1-800-362-2266 (TTY users call 711)
An on call nurse is available if you need to reach us after hours.

If you have special needs with hearing or vision, we will be happy to accommodate you and help you find the services that meet your needs. RiverSpring MAP also provides information in other languages and has free language interpreter services available for non-English speakers.

ELIGIBILITY FOR ENROLLMENT IN THE RIVERSPRING MAP PROGRAM

The RiverSpring MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the RiverSpring MAP Program if you are also enrolled in RiverSring MAP (HMO D-SNP) for Medicare coverage and:

1) Are age **18** and older;
2) Reside in the plan's service area: Bronx, Kings, New York, Richmond, Queens, Nassau and Westchester counties;
3) Have a chronic illness or disability that makes you eligible for services usually provided in a nursing home;
4) Are eligible for nursing home level of care, as of the time of your enrollment, using the Uniform Assessment System (UAS) or other tool designated by the New York State Department of Health;
5) Are capable to return or remain in your home and community without jeopardy to your health and safety, at the time you join the plan; and
6) 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:
   a. Nursing services in the home

b. Therapies in the home
c. Home health aide services
d. Personal care services in the home
e. Adult day health care
f. Private Duty Nursing, or
g. Consumer Directed Personal Assistance Services (CDPAS)

An applicant who is an hospital inpatient or is an inpatient or resident of 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 Disability (OPWDD), or is enrolled in another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a OPWDD Day Treatment Program, or is receiving services from a hospice, may be enrolled with the Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home and Community-Based Services waiver program, CMCM or OPWDD Day Treatment Program.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in RiverSpring MAP Program. Enrollment in the RiverSpring MAP Program is voluntary.

Enrollment

RiverSpring MAP will accept and process applications in the order received, without restriction and without discrimination as to age, sex, race, creed, physical or mental handicap or developmental disability, national origin, sexual orientation, health status, or cost for health services.

RiverSpring MAP will set up a meeting at your home or a nursing home for our Intake Nurse to conduct a comprehensive assessment to determine if you are eligible, and your health care needs for development of your care plan. The Intake Nurse will contact your physician regarding your interest in enrollment, the services covered, and your plan of care.

The New York State Department of Health, in cooperation with New York Medicaid Choice, have established a Conflict Free Evaluation and Enrollment Center (CFEEC) with a system to complete an evaluation to determine if you are eligible for Community-Based Long Term Care. This evaluation and assessment must be completed and on record prior to enrollment in our plan. You will receive a notice from CFEEC indicating your eligibility: if determined to be eligible, the CFEEC Evaluator will connect you with RiverSpring MAP to begin the enrollment process; if determined to be ineligible, you will have fair hearing rights.

For enrollment, you will be asked to sign documents including an enrollment agreement, medical release form, and privacy notice acknowledgment. If you meet the established criteria and your Medicaid is currently active, your enrollment will usually become effective the 1st day of the following month. You will receive a personal RiverSpring MAP identification card that will cover Medicare and Medicaid services. Remember, you need to keep your regular Medicaid card to get services that are not covered under RiverSpring MAP.

Denial of Enrollment

You will be denied enrollment to RiverSpring MAP if you:

- Do not meet the eligibility criteria stated above;
- Are enrolled in one of the following: another managed care plan capitated by Medicaid, a Home and Community-Based Services waiver program, a Hospice, the State OPWDD facility or waiver program, and do not want to disenroll.

Network providers will be paid in full directly by RiverSpring MAP for each service authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered services authorized by RiverSpring MAP, you are not responsible to pay the bill, please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by RiverSpring MAP, or for covered services that are obtained by providers outside of RiverSpring MAP network.

Transitional Care

New enrollees may request to continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider, if the provider meets the plan's provider credentialing process, accepts the plan rate as payment in full, agrees to follow the plan's quality assurance and other policies, and provides medical information about your care to the plan.

If the RiverSpring MAP network provider that you are using for an ongoing course of treatment chooses to no longer participate in the plan, we will provide continued coverage with the existing provider for a transitional period of up to 90 days if the provider accepts the plan rate as payment in full, agrees to follow the plan's quality assurance and other policies, and provides medical information about your care to the plan.

MONTHLY SPENDDOWN

Spend-down or surplus is the amount of net available income determined by the NYC Human Resources Administration (HRA) or Local Department of Social Services (LDSS) that a member must pay to RiverSpring MAP in accordance with the income eligibility requirements for Medicaid. HRA/LDSS will inform you and RiverSpring MAP of the monthly spend-down that you must pay.

You will be expected to pay your spend-down amount to RiverSpring MAP on the 1st of each month starting with the month of enrollment. If you have a problem meeting this responsibility, it is important that you discuss the situation with your Nurse Care Manager.

RiverSpring MAP will notify you in writing if you do not pay your spend-down amount within 30 days after the due date, and has the right to involuntarily disenroll you from the program.

SERVICES COVERED BY RIVERPSRING MAP PLAN

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage. Sections 2 and 3 of RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage explain the rules for using plan providers and getting care in a medical emergency or if urgent care is needed. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Section 4 of RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined RiverSpring MAP, and you have Medicaid, RiverSpring MAP will pay these amounts. You do not have to pay these deductibles and co-payments except for those that apply to chiropractic care unless you are Qualified Medicare Beneficiary (QMB), and pharmacy items. If there is a monthly premium for benefits (see Section 8 of the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services

As a member of our plan, you will get Care Management Services. Our plan will provide you with a care manager who is a health care professional – usually a nurse or a social worker. Your care manager will work with you and your doctor to decide the services you need and develop a care plan. Your care manager will also arrange appointments for any services you need and arrange for transportation to those services. You will receive at least one monthly telephone contact from your care management team. The assessment nurse, as member of your care management team, will make home visits at least twice a year to complete a comprehensive assessment of your health and to identify any changes or needs you may have. We will work cooperatively with your physician regarding your plan of care, as well as other health care professionals to ensure you receive the services you need.

Additional Covered Services

Because you have Medicaid and qualify for the RiverSpring MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary, that is, 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. You must get these services from the providers who are in the RiverSpring MAP network.

If you cannot find a provider in our plan, you must request prior authorization from RiverSpring MAP before receiving any health services from an out-of-network provider, except for medical emergency or urgently needed care.

The following services require prior authorization from your RiverSpring MAP Nurse Care Manager. To request prior authorization, you or your doctor should call RiverSpring MAP at 1-800-362-2266; TTY users call 711.

Benefit	Description of Covered Services
Adult Day Health Care	Include medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services. Services furnished in approved SNF or extension site.
Care Management (Service coordination)	Care management is an individually designed intervention that helps the member get access to needed services and is designed to ensure the member's health and welfare and increase the member's independence and quality of life.
Consumer Directed Personal Assistance Services (CDPAS)	Include some or total assistance with personal hygiene, dressing, feeding, meal preparation, housekeeping, home health aide and nursing tasks. A member, or a person acting on member's behalf (known as a designated representative), self directs and manages the member's personal care and other authorized services. The services are provided by an aide chosen and directed by the member or designated representative.
Benefit	**Description of Covered Services**
Dental Services	Include Medicaid covered preventive, prophylactic and other dental care, such as routine exams, cleaning, x-rays, fillings, and other services to check for any changes or abnormalities that require treatment. You do not need a referral from your PCP to see a dentist.
Durable Medical Equipment Not Covered by Medicare	Include devices and equipment other than medical/surgical supplies, enteral/parenteral formula, and prosthetic or orthotic appliances with the following characteristics: can withstand repeated use for protracted period of time; are used for medical purposes; are generally not useful in the absence of illness or injury, and are usually fitted, designed or fashioned for a particular individual's use.
Hearing Services	Include medically necessary hearing services and products to alleviate disability caused by hearing loss or impairment.
Home Health Care Services Not Covered by Medicare	Include the provision of skilled services not covered by Medicare (e.g. physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or nurse to pre-fill syringes for disabled individuals with diabetes) and/or home health aide services as required by an approved plan of care.
Home Delivered and Congregate Meals	Include congregate and home delivered meals to members who cannot prepare or obtain nutritionally adequate meals.

Inpatient Mental Health Care	Include voluntary or involuntary admissions for inpatient mental health services over the Medicare 190-day lifetime limit.
Medical and Surgical Supplies, Enteral and Parenteral Formula, Nutritional Supplements and Hearing Aid Batteries	These are generally one-time use items routinely paid under Durable Medical Equipment category of fee-for-service Medicaid. Coverage of enteral formula and nutritional supplements are limited to nasogastric, jejunostomy, or gastrostomy tube feeding, to individuals who cannot obtain nutrition through any other means.
Medical Social Services	Include assessment, arranging and providing aid and counseling related to maintaining members at home.
Nursing Home Care Not Covered by Medicare	Include skilled nursing facility days provided by a licensed facility in excess of the first 100 days in the Medicare Advantage benefit period.
Nutrition	Include assessment of nutritional needs and food patterns, development and evaluation of treatment plans, nutritional education and counseling.
Benefit	**Description of Covered Services**
Outpatient Rehabilitation	Medically necessary occupational therapy, physical therapy and speech therapy visits that are ordered by a doctor or other licensed professional.
Prosthetics	Medicaid covered prosthetics, orthotics and orthopedic footwear.
Personal Care	Include medically necessary assistance with activities such as personal hygiene, dressing, feeding, nutritional and environmental support function tasks (meal preparation and housekeeping). Personal care services must be ordered by the member's physician and provided by a qualified person in accordance with the member's plan of care.
Personal Emergency Response Services	An electronic device that enables certain high-risk members to reach out for help during an emergency.
Private Duty Nursing	Provided by a person possessing a license and current registration from the NYS Department of Education to practice as a registered professional nurse or licensed practical nurse. Include medically necessary continuous or intermittent skilled nursing services provided in the member's home in accordance with the ordering physician's written treatment plan.
Social and Environmental	Include services and items to support a member's medical needs and included in the member's plan of care. May include home maintenance

Supports	tasks, homemaker/chore services, housing improvement, and respite care.
Social Day Care	Structured, comprehensive program to provide functionally impaired members with socialization, supervision, monitoring, personal care, and nutrition in a protective setting.
Transportation (Non-Emergency)	To access necessary medical services covered by the plan or Medicaid fee-for-service. Includes public transportation, taxi, livery, ambulette, ambulance (when clinical criteria are met), or other means appropriate to your medical condition, and a transportation attendant to accompany the member, if necessary.
Vision Services	Include eyeglasses, medically necessary contact lenses and poly-carbonate lenses, artificial eyes, low vision aids and services. Exam for refraction is limited to every two (2) years unless justified as medically necessary. Eyeglasses are limited to every two (2) years unless lost, damaged or destroyed.

Limitations

- Enteral formula and nutritional supplements is limited to individuals who cannot obtain nutrition through any other means, and to the following conditions: 1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; and 2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.
- Nursing Home Care is covered for individuals who are considered a permanent placement provided you are eligible for institutional Medicaid coverage.

Getting Care Outside the Service Area

If you plan to be away from home or when you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider. Please notify Member Services as early as possible so that we can help arrange any appropriate services that you may need in the area you will be visiting. You can use your Medicare or Medicaid card or any other health insurance card to access non-covered services in the service area and outside of the service area if the health care provider accepts Medicare or New York State Medicaid. Our plan does not cover urgently needed care or any other care if you receive the care outside of the United States.

Emergency Service

A “medical emergency” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical

attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Emergency services include health care procedures, treatments or services needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.

If you have a medical emergency:

- Get help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center.

- As soon as possible, you or someone on your behalf should notify RiverSpring MAP and your physician so that we and/or your physician can follow-up on your emergency care and help you obtain any services you may need after your condition is stabilized.

Payment for medical emergency services:

- You can receive emergency services from any provider, whether or not the provider is part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you paid for the services yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.

- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.

- If the provider is owed anything, we will pay the provider directly.

- If you have already paid for the service, we will pay you back.

SERVICES NOT COVERED BY RIVERSPRING MAP PLAN

There are some Medicaid services that RiverSpring MAP does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-800-362-2266 if you have a question about whether a benefit is covered by RiverSpring MAP or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription drugs are covered by RiverSpring MAP (HMO D-SNP) Medicare Part D as described in section 6 of the RiverSpring MAP (HMO D-SNP) Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by Medicare.

Certain Mental Health Services, including:
- Intensive Psychiatric Rehabilitation Treatment

- Day Treatment
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
- Partial Hospital Care not covered by Medicare
- Rehabilitation Services to those in community homes or in family-based treatment
- Continuing Day Treatment
- Assertive Community Treatment
- Personalized Recovery Oriented Services

Certain Mental Retardation and Developmental Disabilities Services, including:
- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services
- Methadone Treatment
- Comprehensive Medicaid Case Management
- Directly Observed Therapy for TB (Tuberculosis)
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- HIV COBRA Case Management

FAMILY PLANNING

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

SERVICES NOT COVERED BY RIVERSPRING MAP PLAN

You must pay for services that are not covered by RiverSpring MAP or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by RiverSpring MAP or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Infertility Treatment
- Conversion or Reparative Therapy
- Services of a Provider that is not part of the plan (unless RiverSpring MAP sends you to that provider or issued to you a written prior authorization for that provider)

If you have any questions, call Member Services at 1-800-362-2266.

Service Authorizations, Actions, Appeals and Complaints

You have Medicare and get assistance from Medicaid. Information in this chapter covers your rights

for all of your Medicare and most of your Medicaid benefits. In most cases, you will not use one process for your Medicare benefits and a different process for your Medicaid benefits. You will usually use one process for both. This is sometimes called an "integrated process" because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 12 for more information on the External Appeals process.

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

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

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request:

You or your provider may call our toll-free Member Services number at 1-800-362-2266 or send your request in writing to RiverSpring MAP, 80 West 225th St., Bronx, NY 10463

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

Prior Authorization

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

- Adult Day Health Care
- Community First Choice Option Services
- Consumer Directed Personal Assistance Service
- Non-routine Dental Services
- Durable Medical Equipment
- Hearing Aids
- Home Delivered and Congregate Meals
- Home Health Care
- Medical Social Services
- Mental Health Care, Inpatient over Medicare limit and Outpatient
- Nursing Home Care not covered by Medicare
- Nutrition Services
- Outpatient Rehabilitation Services, including Physical, Occupational, Speech and Respiratory Therapies
- Personal Care Services
- Personal Emergency Response System
- Private Duty Nursing Services
- Prosthetics and Orthotics
- Social and Environmental Supports

- Social Day Care
- Substance Abuse Services, Inpatient and Outpatient
- Vision Care
- Transportation

Concurrent Review
You can also ask RiverSpring MAP (HMO-D-SNP) to get more of a service than you are getting now. This is called **concurrent review**.

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

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

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

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

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you do not agree with our decision.

Standard Process

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

- A standard review for a prior authorization request means we will give you an answer within 3 work days of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision

within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.

- **We can take up to 14 more calendar days** if you ask for more time or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If you believe we should **not** take extra days, you can file a **"fast complaint."** When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our answer is yes to part or all of what you asked for**, we will authorize the service or give you the item that you asked for.
- **If our answer is no to part or all of what you asked for,** we will send you a written notice that explains why we said no. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

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

- A fast review of a prior authorization request means we will give you an answer within 1 work day of when we have all the information we need but no later than **72 hours** from when you made your request to us**.**
- We can take **up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a "fast complaint"** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Section 2: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)
2. Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

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

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

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

- This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan later in this chapter.)

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

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

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

<u>If we are changing a service you are already getting</u>

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

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

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

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

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).
- RiverSpring MAP (HMO D-SNP) can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-800-362-2266 to get more information on your rights and the options available to you.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

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

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

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

If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:

When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good

reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.

- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **"fast appeal."**
  - The requirements and procedures for getting a "fast appeal" are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
  - If your provider tells us that your health requires a "fast appeal," we will give you a fast appeal.
  - If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.
- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at 1-800-362-2266 if you need help filing a Level 1 Appeal.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an "Appointment of Representative" form, or write and sign a letter naming your representative.
    - To get an "Appointment of Representative" form, call Member Services and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.RiverSpringHealthPlans.org. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
    - You can write a letter and send it to us. (Your or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing.

Continuing your service or item while appealing a decision about your care

If we told you we were going to stop, suspend, or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.

- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending
- . You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- **Note:** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-800-362-2266 if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will **automatically** send your case on to the next level of the appeals process.

Timeframes for a "standard" appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services you have not gotten yet.
- We will give you our decision sooner if your health condition requires us to.
- However, if you ask for more time or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**. If we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If you believe we should **not** take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.

- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
  - An independent outside organization will review it.
  - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal.** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a "fast" appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- If you ask for more time or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

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

If our answer is no to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the "**Integrated Administrative Hearing Office" or "Hearing Office,"** reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.

- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 3: Level 2 Appeals

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

If we say **No** to your Level 1 Appeal, your case will **automatically** be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency**. It is not connected with us. Medicare and Medicaid oversee its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a free copy of your case file**.
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 90 calendar days** of when it gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 8 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you its decision in writing and explain the reasons for it.

- If the Hearing Office says **yes** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision**.
- If the Hearing Office says **no** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the Hearing Office says no to part or all of your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.
- The decision you get from the Medicare Appeals Council related to **Medicaid** benefits will be **final**.

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 4: External Appeals for Medicaid Only

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

You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

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

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

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**

- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

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

- You can call Member Services at 1-800-362-2266 if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov .
- Contact the health plan at 1-800-362-2266

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

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

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.

Section 5: What To Do If You Have A Complaint About Our Plan

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

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-800-362-2266 or write to Member Services. **The formal name for "making a complaint" is "filing a grievance."**

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

How to File a Complaint:

Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know. 1-800-362-2266, TTY/TDD users call: 711, 7 days a week from 8 a.m. to 8 p.m. ET.

If you do not wish to call (or you called and were not satisfied), **you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

Our plan accepts grievances orally or in writing, provided the grievance is submitted to us within 60 calendar days after the event or incident that precipitated (led to) the grievance. We will look into your concerns, including obtaining any additional information necessary to fully review your grievance. Our plan will respond to your grievance as fast as your condition requires but no later than 30 calendar days from receiving the grievance. In some circumstances, you may want to file a fast ("expedited") grievance.

Whether you call or write, you should contact Member Services right away. You can make the complaint at any time after you had the problem you want to complain about.

What happens next:

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

We answer most complaints in 30 calendar days.

If you are making a complaint because we denied your request for a "fast service authorization" or a "fast appeal," **we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

However, if you have already asked us for a service authorization or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples of when you can make a complaint:

If you asked us to give you a "fast service authorization" or a "fast appeal" and we said we will not.

If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.

When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.

When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.

If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Complaint Appeals

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

After we get your complaint appeal, we will send you a letter within 15 work days. The letter will tell you:

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

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

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

We will let you know our decision within 30 work days from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 work days of when we have all the information we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale, if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

DISENROLLMENT FROM RIVERSPRING MAP (HMO D-SNP) PROGRAM

RiverSpring MAP (HMO D-SNP) will not pursue disenrollment based on age, sex, race, creed, physical or mental handicap or developmental disability, national origin, sexual orientation, health status, or cost for health services.

<u>You Can Choose to Disenroll</u>:

You can ask to leave the RiverSpring MAP Program at any time for any reason.

To request disenrollment, you may begin the process at any time by writing or calling us. You should discuss your wish with your NCM. You will sign a Disenrollment Form that will let you

know the projected date upon which you will be no longer entitled to receive services through RiverSpring MAP. The effective date of your disenrollment will be as of the first day of the following month, or no later than the first day of the second month following your disenrollment request. It could take up to six weeks to process, depending on when your request is received.

You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Care (CBLTC) services, like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to receive CBLTC services.

You Will Have to Leave RiverSpring MAP Program if you:

- No longer are in RiverSpring MAP (HMO D-SNP) for your Medicare coverage
- Need nursing home care, but are not eligible for institutional Medicaid
- Are out of the plan's service area for more than 90 consecutive days
- Permanently move out of the RiverSpring MAP service area
- No longer require a nursing home level of care
- Join a Long-Term Home Health Care Program, a Home and Community Based Services Waiver program, or are enrolled in a program or become a resident in a facility that is under the auspices of the Offices for People With Developmental Disabilities, or Alcoholism and Substance Abuse Services.

We Can Ask You to Leave the Plan:

We will ask that you leave RiverSpring MAP if

- You or family member or caregiver behaves in a way that prevents the plan from providing the care you need
- You knowingly provide false information or behave in a deceptive or fraudulent way.
- You fail to complete or submit any consent form or other document that is needed to obtain services for you
- Fail to pay or make arrangements to pay money owed to the plan (spenddown/surplus/NAMI)

RiverSpring MAP will work with you to attempt to resolve these issues. If the issues are not resolved, then RiverSpring MAP will notify New York Medicaid Choice of our request for disenrollment.

Any involuntary disenrollment requires the approval of LDSS or HRA. If approved, LDSS or HRA will notify you in writing of the effective date of your disenrollment and your fair hearing rights. RiverSpring MAP will continue to provide or arrange for the provision of the covered services to you until the effective date of your disenrollment. RiverSpring MAP will assist you in transitioning to another plan that fits your needs.

Re-Enrollment Provisions

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, RiverSpring MAP may not

accept your request for re-enrollment.

Rights and Responsibilities

As a member of RiverSpring MAP, you have the right to:

- Receive medically necessary care;
- Timely access care and services;
- Privacy about your medical record and when you get treatment;
- Get information on available treatment options and alternatives presented in a manner and language you understand;
- Get information in a language you understand; you can get verbal translation services free of charge;
- Get information necessary to give informed consent before the start of treatment;
- Be treated with respect and dignity;
- Get a copy of your medical records and ask that the records be amended or corrected;
- Take part in decision about your health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Get care without regard to sex, race, health status, color, age, national origin, sexual orientation, marital status or religion;
- Be told where, when and how to get the service you need from us, including how you can get covered benefits from out-of-network providers;
- Complain to the NYS Department of Health or HRA/LDSS, to use the NYS Fair Hearing System and/or request a NYS External Appeal, where appropriate;
- Appoint someone to speak for you about your care and treatment;
- Make advance directives and plans about your care; and
- Seek assistance from the Participant Ombudsman program.

Your exercise of these rights will not adversely affect the way you will be treated.

As a member of RiverSpring MAP, you have the responsibility to:

- Receive all covered services through RiverSpring MAP, using RiverSpring MAP network providers;
- Follow your plan of care and request changes as needed;
- Obtain prior authorization for covered services, except for pre-approved services;
- Be seen by your physician if a change in your health status occurs;
- Share complete and accurate health information with your health care providers;
- Maintain Medicaid eligibility;
- Notify RiverSpring MAP when you go away or are out of town;
- Inform RiverSpring MAP NCM of any change in your health and let us know if you do not understand or are unable to follow instructions;
- Cooperate with and be respectful of RiverSpring staff;
- Take responsibility if you refuse treatment or do not follow RiverSpring MAP instructions; and
- Make every effort to pay your Medicaid surplus amount owed, if any.

Advanced Directives

There may come a time when you can't decide about your own healthcare. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends and your doctor know what kinds of treatment you do or don't want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your Primary Care Provider (PCP), your family or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you get these documents. They do not change your right to quality healthcare benefits. The only purpose is to let others know what you want if you can't speak for yourself.

- Healthcare Proxy - With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so he or she knows what you want.

- Cardiopulmonary Resuscitation and Do Not Resuscitate (DNR) - You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

- Organ Donor Card - This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver's license to let others know if and how you want to donate your organs.

Information Upon Request

You Will Be Provided with the Following Information Upon Your Request:

- List of the Names, Business Addresses and Official positions of the membership of the Board of Directors, Trustees, Officers, Controlling persons of RiverSpring MAP.
- The most recent annual certified financial statement of RiverSpring MAP.
- Information relating to Consumer Complaints in regard to RiverSpring MAP.
- Written description of the organization of RiverSpring MAP.
- Description of RiverSpring MAP procedures with regard to protecting the confidentiality of medical records and other member information and the quality assurance program.
- Health Practitioners' affiliations with hospitals.
- Description of criteria utilized regarding approval or denial of services.
- Application and qualification requirements for health care providers to participate in RiverSpring MAP.
- A copy of your RiverSpring MAP program record (upon written request).

RiverSpring Health Plans

1-800-362-2266 (TTY 711)
8 a.m. to 8 p.m. ET; 7 days a week.

www.RiverSpringMAP.org