2027

Summary of Benefits



ElderServe MAP

For more information, call us **1-800-362-2266** (TTY/TDD 711)

8 a.m. to 8 p.m. EST. – 7 days a week.

www.ElderServeHealth.org

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ElderServe MAP (HMO D-SNP) | 2027 Summary of Benefits

Introduction

This document is a brief summary of the benefits and services covered by ElderServe MAP (HMO D-SNP) ElderServe MAP (HMO D-SNP) It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of ElderServe MAP (HMO D-SNP) ElderServe MAP (HMO D-SNP) Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage*.

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A. Disclaimers

This is a summary of health services covered by ElderServe MAP (HMO D-SNP) for January 1, 2027. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits call ElderServe MAP (HMO D-SNP) Member Services at the number at the bottom of this page to get one or, you can visit our website at www.ElderServeHealth.org and view it online.

- **ElderServe MAP (HMO D-SNP)** is an (HMO D-SNP) plan with a Medicare and Medicaid contract. Enrollment in ElderServe MAP (HMO D-SNP) depends on Contract renewal. This information is not a complete description of benefits. If you have any questions or would like to speak to someone at our Plan, call the Member Services at 1-800-362-2266 (TTY/ TDD: 711) for more information.
- ElderServe MAP (HMO D-SNP) is a plan for people who need Medicaid home care and long-term care services and covers Medicare services for those who live in the service area and have both Medicare Part A and Part B and have Medicaid.
- Providers and pharmacies may change throughout the year. Please contact Member Services for the most current provider and pharmacy directory.
- The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.
- This information is available free of charge in other formats and languages. If you need this document in an alternate format (such as large print, Braille, audio, or accessible electronic format), auxiliary aids and services, or oral interpretation services, please call Member Services at 1-800-362-2266 (TTY/ TDD: 711) for more information.
- This plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you:
    - Must be eligible for Medicare and Full Medicaid Coverage.
    - Must be capable, at the time of enrollment of returning to or remaining in your home and community without jeopardy to health and safety, based upon criteria provided by New York State Department of Health; and
    - Need at least one Community Based Long Term Services and Supports (CBLTSS) for more than 120 days and the following:
        - individuals with a diagnosis by a physician of Dementia or Alzheimer's and needs help with at least supervision with more than one activity of daily living (ADL); or
        - individuals who are assessed as needing at least limited assistance with physical maneuvering with more than two ADLs.
        -

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

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

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

- Must be 18 years of age or older;
- Must reside in the plan's service area;
- Are determined eligible for long-term care services by the plan or an entity designated by the Department using the current NYS eligibility tool.

- Under ElderServe MAP (HMO D-SNP) you can get your Medicare and most of your Medicaid services in one health plan. An ElderServe MAP (HMO D-SNP) care manager will help manage your health care needs.
- For more information about **Medicare**, you can read the *Medicare & You* handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can access it online at the Medicare website (www.medicare.gov) or request a copy by calling 1-800- MEDICARE (1-800-633-4227), 24 hours per day, 7 days a week. TTY users should call 1-877-486-2048.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-800-362-2266 (TTY/TDD: 711), 8:00 am to 8:00 pm, 7 days a week. The call is free.
- *This document is available for free in* Spanish, Chinese and Russian

B. When you enroll, we will ask your preferred language and/or format for materials, which we will keep on file. You can make a standing request for future mailings, and you can change your preference at any time by calling Member Services. Frequently asked questions

The following table lists frequently asked questions.

Frequently Asked Questions (FAQ)	Answers
What's a Medicaid Advantage Plus (MAP/HMO) + Dual Eligible Special Needs Plan (D-SNP) plan?	Our MAP plan is a Health Maintenance Organization (HMO) aligned with a Dual Eligible (Medicaid and Medicare) Special Needs Plan (D-SNP). Our plan combines your Medicaid home care and long-term care services and your Medicare services. It combines your doctors, hospital, pharmacies, home care, nursing home care, behavioral health care (mental health and substance use/addiction services), and other health care providers into one coordinated health care system. It also has care coordinators to help you manage all of your providers and services. They all work together to provide the care you need. Our MAP plan is called ElderServe MAP (HMO D-SNP)
Will I get the same Medicare and Medicaid benefits in ElderServe MAP (HMO D-SNP) that I get now?	If you're coming to ElderServe MAP (HMO D-SNP) from Original Medicare or another Medicare plan, you may get benefits or services differently. You'll get almost all your covered Medicare and Medicaid benefits directly from ElderServe MAP (HMO D-SNP) When you enroll in ElderServe MAP (HMO D-SNP), you and your Care Team will work together to develop an Individualized Plan of Care to address your health and support needs, reflecting your personal preferences and goals. If you're taking any Medicare Part D drugs that ElderServe MAP (HMO D-SNP) doesn't normally cover, you can get a temporary supply, and we'll help you to transition to another drug or get an exception for ElderServe MAP (HMO D-SNP) to cover your drug if medically necessary. If you're taking any Medicare Part D drugs that ElderServe MAP (HMO D-SNP) doesn't normally cover, you can get a temporary supply and we'll help you to transition to another drug or get an exception for ElderServe MAP (HMO D-SNP) to cover your drug if medically necessary. For more information, call Member Services at the numbers listed at the bottom of this page.

Frequently Asked Questions (FAQ)	Answers
Can I use the same health care providers I use now?	That's often the case. If your providers (including doctors, therapists, pharmacies, and other health care providers) work with ElderServe MAP (HMO D-SNP) and have a contract with us, you can keep going to them. • Providers with an agreement with us are "in-network." You must use the providers in ElderServe MAP (HMO D-SNP)'s network. • If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you can use providers outside of ElderServe MAP (HMO D-SNP)'s network. To find out if your providers are in the plan's network, call Member Services at the numbers listed at the bottom of this page or read ElderServe MAP (HMO D-SNP)'s Provider and Pharmacy Directory. You can also visit our website at www.ElderServeHealth.org for the most current listing. If ElderServe MAP (HMO D-SNP) is new for you, we'll work with you to develop an Individualized Plan of Care (ICP) to address your needs. You can keep using the providers you use now for 90 days or until your ICP is completed. Further, members who enroll on or after January 1, 2027, can continue to use their same behavioral health providers for up to 24 months as part of a continuous episode of care. "Continuous Behavioral Health Episode of Care" means a course of ambulatory behavioral health treatment, other than ambulatory detoxification and withdrawal services, which began prior to the effective date of the behavioral health benefit inclusion into MAP in the geographic service area in which services had been provided to an enrollee at least twice during the six months preceding January 1, 2027 by the same provider for the treatment of the same or related behavioral health condition.

Frequently Asked Questions (FAQ)	Answers
What's a Care Manager?	A Care Manager is your main contact person at our plan. This person helps to manage all of your providers and services and make sure you get what you need. Members may have a Care Manager who works for the Plan as well as a specialized Health Home/Health Home Plus Care Manager (refer to **Section E**. Benefits covered outside of ElderServe MAP (HMO D-SNP)).
What are Managed Long-term Services and Supports (MLTSS)?	Managed Long-term Services and Supports (MLTSS) are help for people who need assistance to do everyday tasks like taking a bath, getting dressed, making food, and taking medicine. Often these services are provided at your home or in your community, but they could also be provided in a nursing home or hospital when necessary. MLTSS is available to members who meet certain clinical and financial requirements.
What happens if I need a service but no one in ElderServe MAP (HMO D-SNP)'s network can provide it?	Most services will be provided by our network providers. If you need a service that can't be provided within our network, such as due to shortage of staff with necessary expertise and/or availability to provide services, ElderServe MAP (HMO D-SNP) will cover services provided by an out-of-network provider.
Where's ElderServe MAP (HMO D-SNP) available?	The service area for this plan includes: Bronx, Kings, New York, Nassau, Queens, Richmond, and Westchester Counties, New York State. You must live in one of these areas to join the plan.

Frequently Asked Questions (FAQ)	Answers
What's prior authorization?	Prior authorization means that you must get approval from ElderServe MAP (HMO D-SNP) before ElderServe MAP (HMO D-SNP) will cover a specific service, item, or drug or out-of-network provider. ElderServe MAP (HMO D-SNP) may not cover the service, item or drug if you don't get prior approval**. If you need urgent or emergency care or behavioral health crisis services or out-of-area dialysis services, you don't need to get approval first**. ElderServe MAP (HMO D-SNP) can provide you with a list of services or procedures that require you to get prior authorization from ElderServe MAP (HMO D-SNP) before the service is provided. Refer to **Chapter 3**, of the *Evidence of Coverage* to learn more about prior authorization. Refer to the Benefits Chart in **Chapter 4** of the *Evidence of Coverage* to learn which services require a prior authorization. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call Member Services at the numbers listed at the bottom of this page for help.
What's a referral?	ElderServe MAP (HMO D-SNP) requires referral only for certain types of Dental Services. A referral means that your primary care provider (PCP) must give you written approval before you can use specialists or other providers in the plan's network. This can be done electronically however if you don't get approval, ElderServe MAP (HMO D-SNP) may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. ElderServe MAP (HMO D-SNP) can provide you with a list of services that require you to get a referral from your dental provider before the service is provided. For more information on when a referral is needed, call Member Services at the numbers listed at the bottom of this or refer to **Chapter 3**, of the *Evidence of Coverage.*
Do I pay a monthly amount (also called a premium) under ElderServe MAP (HMO D-SNP)?	No. Because you have Medical Assistance (Medicaid), you won't pay any monthly premiums for your health coverage. However, you must continue to pay your Medicare Part B premium unless your Part B premium is paid for you by Medical Assistance (Medicaid) or another third party.

Frequently Asked Questions (FAQ)	Answers
Do I pay a deductible as a member of ElderServe MAP (HMO D-SNP)?	No. You don't pay deductibles in ElderServe MAP (HMO D-SNP)
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of ElderServe MAP (HMO D-SNP)?	There's no cost-sharing (copays or deductibles) for medical services in ElderServe MAP (HMO D-SNP), so your annual out-of-pocket costs will be $0.

C. Overview of services

The following table is a quick overview of what services you may need and rules about the benefits.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Inpatient hospital care	$0	Except in an emergency, your health care provider must tell the plan of your hospital admission. Prior Authorization is required.
	Outpatient hospital services (including outpatient treatment by a doctor or a surgeon)	$0	Prior Authorization is required.
	Ambulatory surgical center (ASC) services	$0	Prior Authorization is **not** required.
You want to use an outpatient health care provider	Doctor visits (including visits to Primary Care Providers and specialists)	$0	Visits that do not need prior authorization: ▪ PCP ▪ Emergency care ▪ Urgent care ▪ Immunizations ▪ Palliative Care Visits that may need prior authorization: • Specialist - Only the first 3 visits will not require prior authorization. Authorization is required for all subsequent visits. • Outpatient surgery or services
	Visits to treat an injury or illness	$0	Prior Authorization is **not** required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want to use a health care provider	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	$0	Prior Authorization is not required. For a list of Preventive Services, please see Chapter 4 of the *Evidence of Coverage*.
	Wellness visits, such as a physical	$0	Prior Authorization is not required.
	"Welcome to Medicare" preventive visit (one time only)	$0	Prior Authorization is not required.
You need emergency care	Emergency room services, including mental health emergencies at Comprehensive Psychiatric Emergency Programs (CPEPs)	$0	You may use any emergency room or CPEP if you reasonably believe you need emergency care. You don't need prior authorization, and you don't have to be in-network. Emergency room services AREN'T covered outside of the U.S. and its territories except under limited circumstances. Contact the plan for details.
	Urgent care	$0	Urgent care isn't emergency care. You don't need prior authorization, and you don't have to be in-network. Urgent care ISN'T covered outside the U.S. and its territories except under limited circumstances. Contact the plan for details.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need medical tests	Lab tests, such as blood work	$0	Routine Lab Services do not require authorization. Some Lab Services might require authorization Diagnostic Procedures/Tests: Prior Authorization is required for MRI and PET scans.
	X-rays or other pictures, such as CAT scans	$0	Prior Authorization is **not** required.
	Screenings, such as tests to check for cancer	$0	Prior Authorization is **not** required.
You need hearing/ auditory services (This service is continued on the next page)	Hearing screenings (including routine hearing exams)	$0	Prior Authorization is required. Diagnostic hearing and balance evaluations are limited to 1 per year without prior authorization. All subsequent evaluations will require a prior authorization.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hearing/ auditory services (Continued)	Hearing aids (as well as fittings and associated accessories and supplies)	$0	This is a **Medicaid** covered benefit. Hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. Prior authorization is required for hearing aid replacement parts.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Dental services (including, but not limited to, routine exams and cleanings, X-rays, fillings, crowns, extractions, dentures, and endodontic and periodontal care)	$0	• **Comprehensive Dental:** $0 Copayment for Medicare-covered Comprehensive Dental Services. • **Supplemental Preventive Dental Services:** $0 for coverage of Supplemental Preventive Dental Services are limited to selected service codes. Covered dental services include regular and routine dental services such as preventive dental checkups, cleaning, x-rays, fillings, dentures, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. Prior Authorization is required for some Comprehensive Dental Services. Please refer to the Evidence of Coverage Chapter 4 for complete list of covered dental services.
You need eye care (This service is continued on the next page)	Vision services (including annual eye exams)	$0	Prior Authorization is **not** required.
	Glasses or contact lenses	$0	Eyeglasses limited to one pair every 24 months unless medically necessary. Limited to one pair of eyeglasses or contact lenses after each cataract surgery or contact lenses for certain conditions when eyeglasses will not work. Prior Authorization is **not** required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (continued)	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	$0	**Medicaid Benefit:** Services of optometrists, ophthalmologists, and ophthalmic dispensers such as eyeglasses, medically necessary contact lenses, polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids, and low-vision services. Coverage also includes the repair or replacement of parts, examinations for diagnosis and treatment for visual defects and/or eye disease. Medicaid-covered examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Medicaid covered eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged, or destroyed. Prior Authorization is required.
Annual health related social needs screening and navigation to services	You can connect to organizations in your community that provide services to help with housing, transportation, and care management at no-cost to you, through a regional Social Care Network (SCN).	$0	If you're interested, please call Member Services and we'll connect you to a SCN in your area. The Social Care Navigator will verify your eligibility, tell you more about these services, and help you get connected to them.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (This service is continued on the next page)	Inpatient mental health care (long-term mental health services, including inpatient services in a psychiatric hospital, general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), State Operated Addiction Treatment Centers (ATC), Inpatient addition rehabilitation, Inpatient Medically Supervised Detox, or critical access hospital)	$0	All members are covered by the plan for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. Except in an emergency, your health care provider must tell the plan of your hospital admission. Services may be provided by any Office of Mental Health (OMH) licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws. Prior Authorization is required.
	Adult outpatient mental health care Continuing Day Treatment (CDT) Partial hospitalization	$0	Prior Authorization is required

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult outpatient rehabilitative mental health care Assertive Community Treatment (ACT) Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS) Personalized Recovery Oriented Services (PROS)	$0	Prior Authorization is required
	Adult outpatient rehabilitative mental health and addiction services for members who meet clinical requirements. These are also known as Community Oriented Recovery and Empowerment (CORE) services. CORE services: Psychosocial Rehabilitation (PSR) Community Psychiatric Supports and Treatment (CPST) Empowerment services – peer supports Family Support and Training (FST)	$0	CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition (continued)	Adult mental health crisis services Comprehensive Psychiatric Emergency Program (CPEP) Mobile Crisis and Telephonic Crisis Services Crisis Residential Programs	$0	Prior authorization is **not** required.
You have a mental health condition (continued)	Outpatient mental health care (including, but not limited to, clinical counseling and therapy, peer support, psychosocial rehabilitation, medication management, family psychoeducation, and intensive outpatient models of care) (**Note:** This isn't a complete list of the plan's expanded outpatient mental health services. Call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)	$0	Services may be provided by any OMH licensed, designated, or approved provider agency, or a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, Independent Practitioner Network (IPN) Psychiatrist, Psychologist or Advanced Practice Nurse (APN), or other qualified mental health care professional as allowed under applicable state laws.
You're having a mental health or substance use crisis (continued on next page)	Mobile Crisis services (assessment by telephone or mobile crisis team response); short-term residential crisis stabilization (for mental health crises)	$0	Any approved mobile crisis or licensed crisis residence provider in New York State.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You have a mental health condition or a substance use disorder (continued)	CORE Services (which are person-centered, recovery-oriented mobile behavioral health supports. CORE Services build skills and self-efficacy that promote and facilitate community participation and independence). (**Note:** For more information about CORE Services and to determine whether you're eligible for them, call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage*	$0	CORE services are available to members who meet certain clinical requirements. Anyone can refer or self-refer to CORE Services.
You have a substance use disorder	Inpatient and outpatient substance use disorder treatment services (including, but not limited to, detoxification and withdrawal management, short-term residential services, residential treatment center services, and methadone Medication Assisted Treatment) (**Note:** This isn't a complete list of the plan's expanded substance use disorder services. Call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)	$0	Prior Authorization is **not** required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Prior Authorization is required.
	Nursing home	$0	Prior Authorization is required.
	Custodial care (long-term care in a Nursing Facility)	$0	Services are covered for those who meet nursing facility level of care and whose rehabilitation goals have been met or discontinued with no plan to discharge to the community within 180 days of admission.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	$0	There may be limits on physical therapy, occupational therapy, and speech therapy services. If so, there may be exceptions to these limits. Prior Authorization is required. **Medicaid Benefit:** Outpatient Rehabilitation services – physical therapy (PT), occupational therapy (OT), and speech therapy (ST) – that are ordered by a doctor or other licensed professional are covered as medically necessary (without limits to the number of visits). Ambulance services must be medically necessary. You do not need prior authorization for ambulance services and you do not have to be in-network. Prior Authorization is required for non-emergent ambulance services.
You need help getting to health services	Emergency transportation	$0	Ambulance services must be medically necessary. You do not need prior authorization for ambulance services and you do not have to be in-network. Prior Authorization is required for non-emergent ambulance services.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition	Medicare Part B drugs (including those given by your provider in their office, some oral anti-cancer drugs, and some drugs used with certain medical equipment)	$0	Read the *Evidence of Coverage* for more information on these drugs.
You need drugs to treat your illness or condition (continued)	Medicare Part D drugs Tier 1: Generic and Brand name Drugs	$0 for a *30-day* supply.	There may be limitations on the types of drugs covered. Refer to ElderServe MAP (HMO D-SNP)'s *List of Covered Drugs* at URLwww.ElderServeHealth.org for more information. Once you or others on your behalf pay $2,400 you've reached the catastrophic coverage stage and you pay $0 for all your Medicare drugs. Read the *Evidence of Coverage* for more information on this stage. ElderServe MAP (HMO D-SNP) may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from ElderServe MAP (HMO D-SNP) for certain drugs.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)			You must use certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that can't be met by most pharmacies in your network. These drugs are listed on the plan's website, <formulary name (for example, *List of Covered Drugs*)>, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on www.medicare.gov/plan-compare. You may get your drugs from a network retail pharmacy for a 1-month (30-day) or 3-month (90-day) supply and mail order pharmacies for 3 months (90-day) supply. If you reside in a long-term care facility, you pay the same as at a retail pharmacy for a (31-day) supply. You may get drugs from an out-of-network pharmacy for a 1-month (30-days) supply at the same cost as an in-network pharmacy.
	Over-the-counter (OTC) drugs **Plan covers extra benefits. See "Over-the-Counter (OTC) + Utilities + Grocery Benefit" in Section D.**	$0	There may be limitations on the types of drugs covered. Please refer to ElderServe MAP (HMO D-SNP)'s *List of Covered Drugs* (*Drug List*) for more information.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need foot care	Podiatry services (including routine exams)	$0	Authorization is required after 4 regular visits to a podiatrist. Authorization is required after 6 diabetes-related visits to a podiatrist.
	Orthotic services	$0	Authorization is required for Medicare Covered Diabetic Therapeutic Shoes or Inserts.
You need durable medical equipment (DME) or supplies	Wheelchairs, nebulizers, crutches, roll about knee walkers, walkers, and oxygen equipment and supplies, for example (**Note:** This isn't a complete list of covered DME or supplies. Call Member Services at the numbers listed at the bottom of this page or read the *Evidence of Coverage* for more information.)	$0	Authorization is required for DME equipment (non-disposable items that have a useful shelf life of over one (1) year) with cost of $500 or more. Authorization is required for DME supplies (disposable items that do not have a useful shelf life of over one (1) year) with cost of $250 or more.
You need interpreter services	Spoken language interpreter	$0	Prior authorization is not required.
	Sign language interpreter	$0	Prior authorization is not required.
Other covered services (This service is continued on the next page)	Acupuncture **Plan covers extra benefits. See "Acupuncture" in Section D**	$0	Prior authorization is required.
	Plan Care coordination	$0	None

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Chiropractic services	$0	Prior Authorization is required.
Other covered services (continued)	Diabetic supplies	$0	We cover specific manufacturers for diabetic supplies and services from Roche and LifeScan. Prior Authorization is required.
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) (including preventive screenings, medical examinations, vision and hearing screenings and services, immunizations, lead screening, and private duty nursing services)	$0	EPSDT is for members under 21 years of age.
	Family planning	$0	Family planning services furnished by out-of-network providers are covered directly by Medicaid fee-for-service.
	Hospice care	$0	As determined under Medicare/Medicaid fee-for service.
	Mammograms	$0	Annual screening for individuals age 40 and older. No referral necessary

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Managed Long-term Services and Supports (MLTSS) (including, but not limited to, assisted living services; cognitive, speech, occupational, and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); and social adult day care)	$0	MLTSS provides services for members that need the level of care typically provided in a Nursing Facility and allows them to get necessary care in a residential or community setting. MLTSS is available to all members; specific service authorization, including amount, is indicated in the member's individualized approved Plan of Care. Prior Authorization is required.
	Medical day care (including preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision in an ambulatory care setting)	$0	Medical day care is provided to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living. Prior Authorization is required.
Other covered services (continued)	Personal Care Assistance (PCA) (assistance with daily activities such as bathing, dressing, using the bathroom, shopping, cooking, including health-related tasks performed by a qualified individual in a member's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a member's written plan of care)	$0	Prior Authorization is required.
	Prosthetic services	$0	Prior Authorization is required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Other covered services (continued)	Services to help manage your disease	$0	Prior Authorization is required.

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read ElderServe MAP (HMO D-SNP)'s *Evidence of Coverage*. If you have questions, you can also call ElderServe MAP (HMO D-SNP) Member Services at the numbers listed at the bottom of this page.

D. Additional services ElderServe MAP (HMO D-SNP) covers

This isn't a complete list. Call Member Services at the numbers listed at the bottom or read the *Evidence of Coverage* to find out about other covered services.

Additional services ElderServe MAP (HMO D-SNP) covers	Your costs
Over-the-Counter (OTC) + Utility + Grocery Benefit: $295 You may purchase up to $295 every month of approved OTC items. OTC items can be purchased by using an OTC debit card or by placing an online order through an online catalog. You can use this card to buy over-the-counter (OTC) medicines and health related items. In addition, this benefit can be applied towards payment for utilities, food and produce. The benefit dollars cannot be carried over to the next month. The benefit renews on a monthly basis and will not roll over. The benefit cannot be converted to cash. For eligible members with certain chronic conditions, the Special Supplemental Benefits for Chronically Ill (grocery/utility benefit) combines with the OTC benefit to cover certain grocery items as part of the monthly OTC allowance, which may only be purchased at select pharmacies and/or retailers. The benefits mentioned are a part of special supplemental program for the chronically ill. Some examples of conditions include Cardiovascular Disorder, Hypertension, Osteoarthritis, Endocrine Disorder and Gastrointestinal Disorder. Eligibility for this benefit cannot be guaranteed based solely on your condition. Eligible members will be notified and provided instructions on how to access this benefit.	$0
Acupuncture Services You are covered for up to forty (40) acupuncture visits per year. Prior Authorization not required.	$0

E. Benefits covered outside of ElderServe MAP (HMO D-SNP)

This isn't a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other services not covered by ElderServe MAP (HMO D-SNP) but available through Medicaid fee-for-service.

Other services covered directly by Medicaid fee-for-service	Your costs
CSS (Community Support Services)	$0
Health Home (HH) and Health Home Plus (HH+) Care Management	$0
Certified Community Behavioral Health Clinics (CCBHC)	$0
Children's Crisis Residence Services Youth ages 18-20	$0
Non-emergency Medical Transportation	$0
AIDS Adult Day Health Care	$0
Out-of-Network Family Planning Services	$0
Directly Observed Therapy for Tuberculosis	$0
Medicaid Pharmacy Benefits	$0

F. Services that ElderServe MAP (HMO D-SNP), Medicare, and Medicaid don't cover

The following services aren't covered by our plan. This isn't a complete list. Call Member Services at the numbers listed at the bottom of this page to find out about other excluded services.

Services ElderServe MAP (HMO D-SNP), Medicare, and Medicaid don't cover	
Services that are not medically necessary according to the standards of Original Medicare and New York State Medicaid Program.	Personal and Comfort items
Cosmetic surgery if not medically necessary	Services of a provider that isn't part of the plan, unless the plan sends you to that provider
Services that you get without prior authorization, when prior authorization is required for getting that service.	Services provided outside the United States and its territories.
Naturopath services (uses natural or alternative treatments)	Reversal of sterilization procedures and/or non-prescription contraceptive supplies.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	Fees charged for care by your immediate relatives or members of your household.

G. Your rights and responsibilities as a member of the plan

As a member of ElderServe MAP (HMO D-SNP), you have certain rights concerning your health care. You also have certain responsibilities to the health care providers who are taking care of you. Regardless of your health condition, you can't be refused medically necessary treatment. You can use these rights without losing your health care services. We'll tell you about your rights at least once a year. For more information on your rights, read Evidence *of Coverage.*

Your rights include, but aren't limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about race, ethnicity, national origin, color, religion, creed, sex, age, health status, mental, physical, or sensory disability, sexual orientation, genetic information, ability to pay, or ability to speak English. No health care provider should engage in any practice, with respect to any member that constitutes unlawful discrimination under any state or federal law or regulation.
  - Ask for and get information in other formats (for example, large print, braille, audio) free of charge
  - Be free from any form of physical restraint or seclusion
  - Not be billed by network providers
  - Have your questions and concerns answered completely and courteously
  - Apply your rights freely without any negative effect on the way ElderServe MAP (HMO D-SNP) or your provider treats you
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options, regardless of cost or benefit coverage. This information should be in a format and language you can understand. These rights include getting information on:
  - ElderServe MAP (HMO D-SNP)
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers and Care Managers
  - Your rights and responsibilities
- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year. You can call <phone number> if you want to change your PCP.
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly

- Know about all treatment options, no matter what they cost or whether they're covered
- Refuse treatment as far as the law allows, even if your health care provider advises against it
- Stop taking medicine, even if your health care provider advises against it
- Ask for a second opinion about any health care that your PCP or your Care Team advises you to have. ElderServe MAP (HMO D-SNP) will pay for the cost of your second opinion visit.
- Make your health care wishes known in an advance directive

- **You have the right to timely access to care that doesn't have any communication or physical access barriers**. This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your doctors, other providers, and your health plan. Call <phone number> if you need help with this service
  - Have your *Evidence of Coverage* and any printed materials from ElderServe MAP (HMO D-SNP) translated into your primary language, and/or have these materials read out loud to you if you have trouble seeing or reading. Oral interpretation services will be made available upon request and free of charge.
  - Be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation

- **You have the right to emergency and urgent care when you need it**. This means you have the right to:
  - Get emergency and urgent care services, 24 hours a day, 7 days a week, without prior approval
  - Use an out-of-network urgent or emergency care provider, when necessary

- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private. No personal health information will be released to anyone without your consent, unless required by law.

- Have privacy during treatment

- **You have the right to make complaints about your covered services or care.** This includes the right to:
  - Access an easy process to voice your concerns, and to expect follow-up by ElderServe MAP (HMO D-SNP)
  - File a complaint or grievance against us or our providers. You also have the right to appeal certain decisions made by us or our providers
  - Ask for a State Appeal (State Fair Hearing)
  - Get a detailed reason why services were denied

Your responsibilities include, but aren't limited to, the following:

- **You have a responsibility to treat others with respect, fairness, and dignity.** You should:
  - Treat your health care providers with dignity and respect
  - Keep appointments, be on time, and call-in advance if you're going to be late or have to cancel
- **You have the responsibility to give information about you and your health.** You should:
  - Tell your health care provider your health complaints clearly and provide as much information as possible
  - Tell your health care provider about yourself and your health history
  - Tell your health care provider that you're an ElderServe MAP (HMO D-SNP) member
  - Talk to your PCP, Care Manager, or other appropriate person about seeking the services of a specialist before you go to a hospital (except in cases of emergency)
  - Tell your PCP, Care Manager, or other appropriate person within 24 hours of any emergency or out-of-network treatment
  - Notify ElderServe MAP (HMO D-SNP) Member Services if there are any changes in your personal information, such as your address or phone number
- **You have the responsibility to make decisions about your care, including refusing treatment.** You should:
  - Learn about your health problems and any recommended treatment, and consider the treatment before it's performed
  - Partner with your Care Team and work out treatment plans and goals together

- Follow the instructions and plans for care that you and your health care provider have agreed to, and remember that refusing treatment recommended by your health care provider might harm your health

- **You have the responsibility to obtain your services from ElderServe MAP (HMO D-SNP)** You should:
  - Get all your health care from ElderServe MAP (HMO D-SNP), except in cases of emergency, urgent care, behavioral health crisis services, out-of-area dialysis services, or family planning services, unless ElderServe MAP (HMO D-SNP) provides a prior authorization for out-of-network care
  - Not allow anyone else to use your ElderServe MAP (HMO D-SNP) Member ID Card to obtain healthcare services
  - Notify ElderServe MAP (HMO D-SNP) when you believe that someone has purposely misused ElderServe MAP (HMO D-SNP) benefits or services

For more information about your rights, you can read the *Evidence of Coverage*. If you have questions, you can also call ElderServe MAP (HMO D-SNP) Member Services at the numbers listed at the bottom of this page.

H. How to file a complaint or appeal a denied service

If you have a complaint or think ElderServe MAP (HMO D-SNP) should cover something we denied, call ElderServe MAP (HMO D-SNP) at 1-800-362-2266. You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of the *Evidence of Coverage*. You can also call ElderServe MAP (HMO D-SNP) Member Services at the numbers listed at the bottom of this page

If you have a complaint or think ElderServe MAP (HMO D-SNP) should cover something we denied, call ElderServe MAP (HMO DSNP) at 1-800-362-2266 (TTY/TDD: 711), 7 days a week from 8:00 am to 8:00 pm. You may be able to appeal our decision.

You can send us your complaint, grievance and appeals to:

I. 80 West 225th Street, Bronx, N.Y. 10463 Fax: 1-888-341-5009What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, contact us.

- Call us at ElderServe MAP (HMO D-SNP) Member Services. Phone numbers are listed at the bottom of this page.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free.
- Or, call the New York State Medicaid Fraud Hotline 1–877–87 FRAUD.

You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

Phone: 1-866-712-7197

Mail: New York State Department of Health Bureau of Consumer Services

99 Washington Ave/ One Commerce Plaza 16th Fl

Albany, NY 12210 E-mail: mltccomplaints@health.ny.gov

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, call ElderServe MAP (HMO D-SNP) Member Services:

1-800-362-2266
Calls to this number are free. We are open 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

TTY/TDD users call 711.
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free. We are open 7 days a week from 8:00 am to 8:00 pm.

If you need immediate behavioral health care, call the Behavioral Health Crisis Line:

1-800-362-2266
Calls to this number are free. We are open 24 hours a day, 7 days a week ElderServe MAP (HMO D-SNP) also has free language interpreter services available for non-English speakers.

TTY/TDD users call 711.
Calls to this number are free. We are open 24 hours a day, 7 days a week.

A. Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 800-362-2266 TTY:711.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 800-362-2266 TTY:711.	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 800-362-2266 TTY:711 。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 800-362-2266 TTY:711.	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 800-362-2266 TTY:711 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 800-362-2266 TTY:711.	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 800-362-2266 TTY:711.	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 800-362-2266 TTY:711.	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 800-362-2266 TTY:711.	French Creole

אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 800-362-2266TTY:711	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 800-362-2266 TTY:711.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 800-362-2266 TTY:711.	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 800-362-2266 TTY:711-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 800-362-2266 TTY:711.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 800-362-2266 TTY:711.	Greek
800-توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 362-2266 TTY:711-	Urdu