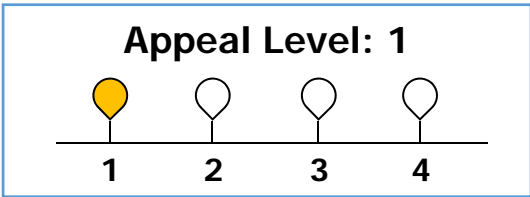


Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]



NOTICE OF APPEAL DECISION DELAY

Name:

Date of Notice:

Participant Number:

[Insert other identifying information, as necessary (e.g., provider name, Participant's Medicaid number, service subject to notice, date of service)]

Dear <Participant name> ,

On <date appeal received, orally or in writing> *[for expedited appeals insert: at <hour received>]* you, or someone acting for you, appealed the following action: *[Insert a brief description of the FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved.]*

[Insert the following section if the Participant (or his/her representative) requested the extension:]

You asked us to delay our appeal decision

You, or someone representing you, requested more time before <plan name> makes its decision on your appeal. We received your extension request on <date>. You requested more time because: *[Give a brief description of the Participant's request. Include the reason or purpose of the extension (e.g. submitting documentation for review, obtaining specialist review of Participant medical condition, etc.), if known.]*

Due to this request, we extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. If you no longer want the extension, call <plan name> immediately at: <phone number>. TTY users call <TTY number>.

[Insert the following section if the plan initiated the extension:]

We delayed our appeal decision

We extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. We delayed the decision because: *[Explain why the decision was delayed. For example, the receipt of additional medical evidence from noncontract providers may be crucial to the appeal decision.]*

This delay is in your interest and is allowed by federal regulation. If you think this delay is inappropriate, read "You can file a fast grievance" below for information about your rights.

[Insert the following section if the plan needs additional information from the Participant to decide the appeal:]

What we need from you

To help us decide your appeal, please submit the following information or materials: *[Request any items from the Participant which may have prompted the delay, e.g. witness statements, non-network provider records, etc.]*

Send the information or materials by mail, fax, or phone to:

<Plan name>
<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>
Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

You can file a fast grievance

If you think we made a mistake by extending the appeal decision deadline, you or someone acting for you can file a fast grievance (also known as an "expedited" grievance). This will allow someone

else at <plan name> to decide whether the extension is appropriate. We will respond to your grievance within 24 hours. Follow these steps to file a fast grievance.

Step 1 – Gather your information and materials. You will need the following:

- Your name
- Your date of birth (or other identifying information, like your Participant number)
- Your contact information (for example: your phone or mailing address)
- Reason(s) why delaying the decision is not in your interest
- Any evidence or information that you want us to review to support why delaying a decision is not in your interest

[If the plan requires any specific information to address the grievance, insert the following text:]

Please submit the following specific information to help us reach a decision on your grievance:

Step 2 – Send the information and materials by mail, fax, or phone. You can also deliver it in person, or give it to your Care Manager.

Grievance Contact Information:

- Phone..... <phone number>
- Regular Mail..... <address>
- Fax..... <fax number>
- Delivery in Person..... <address>
- Contacting your Care Manager..... <phone number>

If you want someone to represent you

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, attorney, or an ICAN staff member (see below).

If you already named someone to represent you when you requested this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. Send your letter or form to us by fax or mail, or give it to your Care Manager. If you have any questions about naming your representative, such as what to say in your letter, call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the FIDA program. ICAN is independent, and the services are available

to you for free. They can help answer your questions about the appeals process, give you advice, and may even represent you. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[Plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:]

A copy of this notice has been sent to: <name>
<address>
<phone number>

Get help & more information

(TTY users call 711, then use the phone numbers below)

- <Plan name>
Toll Free Phone: <phone number>
<hours of operation>
- Independent Consumer Advocacy Network (ICAN)
<http://icannys.org>
Email: ICAN@cssny.org
Toll Free Phone: 1-844-614-8800
8:00am – 8:00pm, Monday – Sunday
- Health Insurance Information, Counseling and Assistance Program (HIICAP)
Toll Free Phone: 1-800-701-0501
- 1-800-MEDICARE (1-800-633-4227)
TTY users call: 1-877-486-2048
24 hours a day, 7 days a week
- NYS Department of Health
Bureau of Managed Long Term Care
Toll Free Phone: 1-866-712-7197
- Medicare Rights Center
Toll Free Phone: 1-888-HMO-9050

<Plan's legal or marketing name> is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. *[This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

You can also ask for this information in other formats, such as Braille or large print.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.