healthfirst
Health Insurance for New Yorkers

2027
Summary of Benefits

CompleteCare (HMO D-SNP)

This Medicaid Advantage Plus plan may be right for you if you're eligible for Medicare and full Medicaid coverage with added long-term care services and would benefit from coordinated care.

New York City, and Nassau, Orange, Rockland, Sullivan, and Westchester counties

January 1, 2027–December 31, 2027



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healthfirst
Health Insurance for New Yorkers

Healthfirst Medicare Advantage Plan

Healthfirst Representative, please indicate the type of Medicare Advantage plan being discussed:

- ○ Preferred Provider Organization (PPO)
- ○ Health Maintenance Organization (HMO)
- ○ Dual-Eligible Special Needs Plan (HMO D-SNP)

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at **1-877-237-1303** (TTY 1-888-542-3821), **7 days a week, 8am–8pm**.

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit **HFMedicareMaterials.org** or call **1-877-237-1303** (TTY 1-888-542-3821) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the Healthfirst network. If they are not listed, it means you will likely have to select new doctors, or enroll in a PPO plan to visit out-of-network providers.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for prescription medicines is in the Healthfirst network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding the Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums, and/or copayments/coinsurance may change on **Jan. 1, 2028**.
- ☐ For an HMO plan, except in emergency or urgent situations, we do not cover services from out-of-network providers (doctors who are not listed in our provider directory).
- ☐ For a preferred provider organization plan (PPO), you are allowed to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher copay for services you receive from non-contracted providers.
- ☐ For a dual-eligible special needs plan (D-SNP), your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.
- ☐ Effect on Current Coverage. If you are currently enrolled in a Medicare Advantage plan, your existing plan coverage will end once your new Medicare Advantage plan coverage starts. If you currently have TRICARE,® your coverage may be affected once your new Medicare Advantage plan coverage starts. Please contact TRICARE for more information. If you have a Medigap plan, once your new Medicare Advantage plan coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.

Introduction

This document is a brief summary of the benefits and services covered by CompleteCare. 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 CompleteCare. 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 CompleteCare for 2027. This is only a summary. Read the *Evidence of Coverage* for the full list of benefits. For a full list of services, look through this plan's *Evidence of Coverage* (EOC), which can be found online at **HFMedicareMaterials.org**. Healthfirst members can call 1-888-260-1010 (TTY 1-888-542-3821) to request a mailed copy.

- Coverage is provided by Healthfirst Health Plan, Inc., which offers HMO plans with a Medicare contract. Our SNPs also have contracts with the New York State Medicaid Program. Enrollment in Healthfirst Medicare Plan depends on contract renewal. Dental services must be medically necessary; limitations and exclusions apply. No out-of-pocket costs for entry-level hearing aids. Eyewear allowance can only be used at participating retailers. DentaQuest® is contracted with Healthfirst to provide dental benefits to its members. Telemedicine (Teladoc Health) and the Nurse Help Line aren't replacements for your primary care provider (PCP). Your PCP should always be your first choice for care (both in-person and virtual visits).
- 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 (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 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), Monday to Friday, 8am–8pm (April through September). The call is free.
- This information is available for free in other languages. Please call our Member Services number at 1-888-260-1010, TTY number 1-888-542-3821, 7 days a week, from 8am–8pm.
- Esta información está disponible en forma gratuita en otros idiomas. Por favor, llame a nuestro número de Servicios a los Miembros al 1-888-260-1010, o al 1-888-867-4132 para los usuarios de TTY, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.
- 本資訊有其他語言版本供免費索取。請致電我們的會員服務部，電話號碼是1-888-260-1010，聽力語言殘障服務專線TTY 1-888-542-3821，服務時間每週七天，每天上午8時至晚上8時。
- ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).
- 请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-866-305-0408 (TTY: 1-888-542-3821)。
- For your convenience, we will send all future mailings and communications to your current contact information on file so you don't need to provide your mailing address/email to us again (unless it has changed). To update your contact information, preferred language, and/or preferred format (such as braille and large print), please contact Member Services at the number on the bottom of this page.

B. 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)?	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 healthcare providers into one coordinated healthcare system. It also has Care Managers 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 CompleteCare.
Will I get the same Medicare and Medicaid benefits in CompleteCare that I get now?	If you're coming to CompleteCare from Original Medicare or another Medicare plan, you may get benefits or services differently. You'll get almost all of your covered Medicare and Medicaid benefits directly from CompleteCare. When you enroll in CompleteCare, 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 CompleteCare 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 CompleteCare to cover your drug if medically necessary. If you're taking any Medicare Part D drugs that CompleteCare 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 CompleteCare to cover your drug if medically necessary. For more information, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) or at the numbers listed at the bottom of this page or at the numbers in the footer of this document.

Frequently Asked Questions (FAQ)	Answers
Can I use the same healthcare providers I use now?	That's often the case. If your providers (including doctors, therapists, pharmacies, and other healthcare providers) work with CompleteCare 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 CompleteCare'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 CompleteCare's network. To find out if your providers are in the plan's network, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821 for English or 1-888-867-4132 for Spanish), or read CompleteCare's Provider and Pharmacy Directory. You can also visit our website at **HFMedicareMaterials.org** for the most current listing. If CompleteCare 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.
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 makes 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 CompleteCare).

Frequently Asked Questions (FAQ)	Answers
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 CompleteCare'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 because of shortage of staff with necessary expertise and/or availability to provide services, CompleteCare will cover services provided by an out-of-network provider.
Where's CompleteCare available?	The service area for this plan includes the following New York State counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Westchester, Orange, Rockland, and Sullivan. You must live in one of these areas to join the plan.
What's prior authorization?	Prior authorization means that you must get approval from CompleteCare before CompleteCare will cover a specific service, item, drug or out-of-network provider. CompleteCare 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.** CompleteCare can provide you with a list of services or procedures that require you to get prior authorization from CompleteCare 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 1-888-260-1010 (TTY 1-888-542-3821) or at the numbers listed at the bottom of this page or at the numbers in the footer of this document for help.

Frequently Asked Questions (FAQ)	Answers
What's a referral?	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, CompleteCare may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. CompleteCare can provide you with a list of services that require you to get a referral from your PCP before the service is provided. For more information on when a referral is needed, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) or refer to **Chapter 3** of the *Evidence of Coverage*.
Do I pay a monthly amount (also called a premium) under CompleteCare?	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.
Do I pay a deductible as a member of CompleteCare?	No. You don't pay deductibles in CompleteCare.
What's the maximum out-of-pocket amount that I'll pay for medical services as a member of CompleteCare?	There's no cost-sharing (copays or deductibles) for medical services in CompleteCare, so your annual out-of-pocket costs will be $0.

Frequently Asked Questions (FAQ)	Answers
Who can join the Healthfirst CompleteCare plan?	To join the Healthfirst CompleteCare plan, you: • Must be age 18 or older; • Must have full Medicaid coverage; • Must have evidence of Medicare Part A & B coverage; • Must be enrolled in CompleteCare's Medicare Advantage product; • Must reside in the service area; • Must be eligible for nursing home level of care (as of the time of enrollment); • Must be a United States citizen or be lawfully present in the United States; • Must be capable, at the time of enrollment, of returning to or remaining in your home and community without jeopardizing your health and safety, based on criteria provided by the New York State Department of Health; • Must be in need of Community Based Long-Term Services and Supports (CBLTSS) which are listed below for more than 120 days from the effective date of enrollment and meet the minimum needs requirements as follows: ◦ at least limited assistance with physical maneuvering with more than two activities of daily living (ADL); or ◦ individuals with a Dementia or Alzheimer's diagnosis, at least supervision with more than one ADL CBLTSS include: ◦ nursing services in the home; ◦ therapies in the home; ◦ home health aide services; ◦ personal care services in the home; ◦ private duty nursing; ◦ adult day healthcare; or ◦ Consumer Directed Personal Assistance Services • For those continuously enrolled in a Managed Long Term Care Plan (MLTC), Medicaid Advantage Plus Plan (MAP) and PACE as of September 1, 2025, do not need to meet the minimum needs criteria.

Frequently Asked Questions (FAQ)	Answers
Which doctors, hospitals, and pharmacies can I use?	Healthfirst CompleteCare has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that aren't in our network, the plan may not pay for these services. You must use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan's provider and pharmacy directory at our website (**HFDocFinder.org**). Or call us and we'll send you a copy of the provider and pharmacy directories.

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, and benefit information (rules about benefits)
You need hospital care	Inpatient hospital care	$0	Except in an emergency, your healthcare provider must tell the plan of your hospital admission. Prior authorization is required for elected admissions.
	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 required.
You want to use an outpatient healthcare provider	Doctor visits (including visits to primary care providers and specialists)	$0	Prior authorization may be required.
	Visits to treat an injury or illness	$0	
	Preventive care (care to keep you from getting sick, such as flu shots and other immunizations)	$0	
	Wellness visits, such as a physical	$0	
	"Welcome to Medicare" preventive visit (one time only)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need emergency care (this service is continued on the next page)	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. CompleteCare also covers emergency services worldwide, including transportation, which are subject to a maximum plan benefit allowance of $200,000 per calendar year. Please refer to the *Evidence of Coverage* for further details.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need emergency care (continued)	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. CompleteCare also covers urgent care services worldwide, including transportation, which are subject to a maximum plan benefit allowance of $200,000 per calendar year. Please refer to the *Evidence of Coverage* for further details.
You need medical tests	Lab tests, such as blood work	$0	Prior authorization is required.
	X-rays or other pictures, such as CAT scans	$0	
	Screenings, such as tests to check for cancer	$0	
You need hearing/ auditory services	Hearing screenings (including routine hearing exams)	$0	Prior authorization is not required.
	Hearing aids (as well as fittings and associated accessories and supplies)	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and 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, implants, and endodontic and periodontal care)	$0	Members must get dental treatment from in-network providers. If you need to find a dentist, visit **HFDocFinder.org** or call 1-800-508-2047 (TTY 1-800-466-7566). For additional information, including exclusions, please refer to the plan's *Evidence of Coverage* document. You can access Healthfirst CompleteCare's Dental Benefit Limitations and Exclusions Guide online at **HFMedicareMaterials.org**. Prior authorization may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need eye care (this service is continued on the next page)	Vision services (including annual eye exams)	$0	As a dual-eligible member, you're covered under your Medicaid benefit for the following: • Medicaid-covered examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Includes one (1) Routine Eye Exam per calendar year. Additional vision benefits include: • one (1) yearly glaucoma screening (for those at high risk). Must use an in-network provider. Please see **Chapter 4** of the plan's *Evidence of Coverage* for more information. Prior authorization is not required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need eye care (continued)	Glasses or contact lenses	$0	As a dual-eligible member, you're covered under your Medicaid benefit for the following: Covered contact lenses (as medically necessary) and low-vision aids. Additional benefits include: • a $400/year allowance for frames, lenses and contact lenses • one contact lens fitting every calendar year Prior authorization is not required.
	Other vision care (including diagnosis and treatment for diseases and conditions of the eye)	$0	Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye. Please refer to **Chapter 4** of your *Evidence of Coverage* for more information. Prior authorization is not required. You must use an in-network provider.
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, and 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	Except in an emergency, your healthcare provider must tell the plan of your hospital admission. Prior authorization is required.
	Adult outpatient mental health care • Continuing Day Treatment (CDT) • Partial hospitalization	$0	Prior authorization is required.
	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 may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You have a mental health condition (continued)	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	
	Adult mental health crisis services • Comprehensive Psychiatric Emergency Program (CPEP) • Mobile Crisis and Telephonic Crisis Services • Crisis Residential Programs	$0	Prior authorization may be required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
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 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) or read the *Evidence of Coverage* at **HFMedicareMaterials.org** 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. Prior authorization may be required.
You're having a mental health or substance use crisis	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, and benefit information (rules about benefits)
You have a mental health condition or a substance use disorder	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 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) or read the *Evidence of Coverage* at **HFMedicareMaterials.org**.)	$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, and benefit information (rules about benefits)
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, i.e., Medication Assisted Treatment) (Note: This isn't a complete list of the plan's expanded substance use disorder services. Call Member Services at 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) or read the *Evidence of Coverage* at **HFMedicareMaterials.org** for more information.)	$0	Prior authorization is required.
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. Prior authorization is required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need therapy after a stroke or accident	Occupational, physical, or speech therapy (outpatient or in-home)	$0	Prior authorization is required.
You need help getting to health services	Emergency transportation	$0	
You need drugs to treat your illness or condition (this service is continued on the next page)	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* at **HFMedicareMaterials.org** for more information on these drugs. Prior authorization is required.
	Medicare Part D drugs Tier 1 Part D drugs	$0	There may be limitations on the types of drugs covered. Refer to CompleteCare's Comprehensive Formulary at **HFMedicareMaterials.org** for more information. Once you or others on your behalf pay $2,400, you have 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.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Medicare Part D drugs	$0	CompleteCare 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. CompleteCare covers most Part D vaccines at no cost to you. Call Member Services at 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) for more information. Your provider must get prior authorization from CompleteCare for certain drugs. 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, Comprehensive Formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on **medicare.gov/plan-compare**.
You need drugs to treat your illness or condition (continued)	Over-the-counter (OTC) drugs	$0	There may be limitations on the types of drugs covered. Please refer to CompleteCare'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, and benefit information (rules about benefits)
You need foot care	Podiatry services (including routine exams)	$0	As a dual-eligible member, you also receive Medicaid coverage of medically necessary foot care, including care for medical conditions affecting lower limbs. This includes up to four visits per year for routine foot care. The plan also covers 15 supplemental routine foot care visits per calendar year. Prior authorization is not required.
	Orthotic services	$0	Prior authorization is required.
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 1-888-260-1010 (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September) or read the *Evidence of Coverage* at **HFMedicareMaterials.org** for more information.)	$0	Prior authorization is required.
You need interpreter services	Spoken language interpreter	$0	If you need these services, please contact Member Services.
	Sign language interpreter	$0	

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
Other covered services (these services are continued on the next page)	Acupuncture	$0	Original Medicare covers up to 12 visits in 90 days for covered beneficiaries experiencing chronic low back pain. For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight (8) sessions will be covered for those patients demonstrating an improvement. Our plan also covers an additional 40 supplemental visits for other conditions including chronic low back pain per calendar year. Prior authorization is not required.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
Other covered services (continued)	Plan care coordination	$0	
	Chiropractic services	$0	Covered services include: • Manual manipulation of the spine to correct subluxation • Extraspinal manipulation • Evaluation and management services • Physical medicine modalities and procedures • X-rays You must use an in-network provider. Prior authorization is required.
	Diabetic supplies	$0	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.

Health need or problem	Services you may need	Your costs for in-network providers	Limitations, exceptions, and benefit information (rules about benefits)
Other covered services (continued)	Hospice care	$0	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services, related to your terminal prognosis, are paid for by Original Medicare, not CompleteCare. Please read the *Evidence of Coverage* for more details.
	Mammograms	$0	
	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 who 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. Residential modifications improvements **don't** include permanent and/or structural changes to someone's residence. Limitations and exclusions apply to residential modifications. Prior authorization is required.

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

The above summary of benefits is provided for informational purposes only. For more information about your benefits, you can read CompleteCare's *Evidence of Coverage*. If you have questions, you can also call Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

D. Additional services CompleteCare covers

This isn't a complete list. Call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) or read the *Evidence of Coverage* to find out about other covered services.

Additional services CompleteCare covers	Your costs
OTC Plus card with $256/month ($3,072/year) allowance that you can use to purchase over-the-counter non-prescription drugs, exercise equipment, activity trackers, and health-related items. If eligible, you can also use the allowance for healthy foods, personal care items, household cleaning supplies, and home utilities such as gas, oil, electric, water, and cell phone bills, and internet service.* *These are special supplemental benefits for members enrolled in a Healthfirst dual-eligible special needs plan. To be eligible, you must have a chronic condition such as cardiovascular disorder, disabling mental health condition, diabetes, lung disorders, obesity, or another eligible condition not listed. Benefit eligibility is not based on your chronic condition alone.	$0
Wellness programs, health education and nutritional counseling	$0
SilverSneakers,® which gives you access to thousands of fitness locations, more than 80 different types of instructor-led classes and workshops, on-demand video library of classes, workouts, and how-to videos, and much more—all at no additional cost to you.	$0
Emergency care is covered in the U.S. and worldwide (outside the U.S.).	$0
Personal Emergency Response System (PERS): A device that you can use to get help in an emergency.	$0
Caregiver support services provided by Carallel® for caregivers of enrollees. There is no cost to use this benefit. Carallel's Care Advocates provide support and research on topics like health insurance, emotional support, stress management, housing and transportation, and guidance on financial matters and legal concerns. Carallel offers online tools and resources that provide personalized support tailored to your unique situation. Caregiver support services (counseling and training) are designed to equip caregivers with the necessary skills, knowledge, and support to provide care to the enrollee. Sign up for Carallel's caregiver support services by calling 1-855-606-1880, Monday to Friday, 8am–7pm. TTY users call 711. Sign up online at **app.carallel.com/healthfirst**.	$0

Worldwide emergency/urgent care services, including transportation, are subject to a maximum plan benefit allowance of $200,000 per calendar year.

Healthfirst CompleteCare will not cover any Part D drugs that you receive as part of your emergency or urgent care visit in another country.

For reimbursement from Healthfirst, members must submit an itemized proof of payment and medical records of the care received to Healthfirst.

For more information you can read CompleteCare's *Evidence of Coverage*.

Since you qualify for Medicare and Medicaid, you may also qualify for Supplemental Security Income (SSI). It pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. For more information, contact your local Social Security office at 1-800-772-1213 (TTY 1-800-325-0778).

E. Benefits covered outside of CompleteCare

This isn't a complete list. Call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) to find out about other services not covered by CompleteCare 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 services	$0
Certified Community Behavioral Health Clinics (CCBHC)	$0
Children's Crisis Residence Services Youth ages 18–20	$0
Assisted-Living Program	$0
Comprehensive Medicaid Case Management	$0
Directly Observed Therapy for Tuberculosis	$0
The New York State Office for People With Developmental Disabilities (OPWDD)	$0
Out-of-Network Family Planning Services	$0
Non-Emergency Medical Transportation	$0

F. Services that CompleteCare, 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 1-888-260-1010 (TTY 1-888-542-3821) to find out about other excluded services.

Excluded means that CompleteCare or Medicaid doesn't cover these services.

Services that CompleteCare, Medicare, and Medicaid don't cover
Personal and comfort items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
Radial keratotomy, and LASIK surgery.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.
Naturopath services (natural or alternative treatments).
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.

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

As a member of CompleteCare, you have certain rights concerning your healthcare. You also have certain responsibilities to the healthcare 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 the *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 healthcare 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 CompleteCare or your provider treats you
- **You have the right to get information about your healthcare**. 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:
  - CompleteCare
  - The description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of healthcare 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 1-888-260-1010 (TTY 1-888-542-3821) if you want to change your PCP.
  - Use a women's healthcare 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 healthcare provider advises against it
  - Stop taking medicine, even if your healthcare provider advises against it
  - Ask for a second opinion about any healthcare that your PCP or your Care Team advises you to have. CompleteCare will pay the cost of your second-opinion visit.
  - Make your healthcare 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 healthcare 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 1-888-260-1010 (TTY 1-888-542-3821) if you need help with this service.
  - Have your *Evidence of Coverage* and any printed materials from CompleteCare 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 CompleteCare
  - 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 healthcare 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 yourself and your health.** You should:
  - Tell your healthcare provider your health complaints clearly and provide as much information as possible
  - Tell your healthcare provider about yourself and your health history
  - Tell your healthcare provider that you're a CompleteCare 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 Healthfirst 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 healthcare provider have agreed to, and remember that refusing treatment recommended by your healthcare provider might harm your health

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

For more information about your rights, you can read CompleteCare's *Evidence of Coverage*. If you have questions, you can also call CompleteCare Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

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

If you have a complaint or think CompleteCare should cover something we denied, call CompleteCare at 1-888-260-1010 (TTY 1-888-542-3821). You can file a complaint or appeal our decision.

For questions about complaints and appeals, you can read **Chapter 9** of CompleteCare's *Evidence of Coverage*. You can also call Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide participants/members free, confidential assistance on any services offered by Healthfirst Health Plan, Inc. ICAN may be reached toll-free at 1-844-614-8800, Monday to Friday, 8am–6pm, or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

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 Avenue/One Commerce Plaza
  16th Floor
  Albany, NY 12210
- E-mail: mltccomplaints@health.ny.gov

I. What to do if you suspect fraud

Most healthcare 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 our Member Services at 1-888-260-1010 (TTY 1-888-542-3821).
- 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.

If you have general questions or questions about our plan, services, service area, billing, or Member ID cards, call Healthfirst Member Services:

1-888-260-1010

Calls to this number are free.

7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September). Member Services also has free language interpreter services available for non-English speakers.

Healthfirst provides the following: free aids and services to people with disabilities to help you communicate with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, and other formats). If you need these services, call Healthfirst at 1-866-305-0408. For TTY services, call 1-888-542-3821.

Member Services also has free language interpreter services available for non-English speakers. If you need these services, call Healthfirst at 1-866-305-0408. For TTY services, call 1-888-542-3821.

TTY 1-888-542-3821

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September).

If you have questions about your health:

- Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- If your PCP's office is closed, you can also call our Nurse Help Line. A nurse will listen to your problem and tell you how to get care. (Example: [convenience care,] urgent care, emergency room). The numbers for the Nurse Help Line are:

1-855-NURSE33 (1-855-687-7333)

Calls to this number are free. 7 days a week, 24 hours a day (TTY 711). CompleteCare also has free language interpreter services available for non-English speakers.

TTY 1-888-542-3821

Calls to this number are free. 7 days a week, 8am–8pm (October through March); Monday to Friday, 8am–8pm (April through September).

If you need immediate behavioral health care, call Member Services at:

1-888-260-1010

Calls to this number are free.

7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September).

If you need immediate medical assistance, please dial 911 or go to the emergency room at your local hospital. If you're in distress, call or text **988** for free confidential support 24/7, or visit **988lifeline.org** for additional chat options, and prevention and crisis resources.

The following free aids and services are available to people with disabilities to help you communicate with us: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, and other formats). CompleteCare also has free language interpreter services available for non-English speakers.

If you need these services, call Healthfirst at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

Calls to this number are free. 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September).

Healthfirst CompleteCare (HMO D-SNP) Dental

Dental health is an important part of your overall well-being. The CompleteCare plan's dental benefits include a wide range of services designed to help you maintain a healthy smile. Some of the services the plan includes are:

Service category	Service	You pay
Preventive/ Diagnostic Services	Dental Exams	$0
	Routine Cleanings	$0
	Dental X-rays	$0
Comprehensive Services	Fillings	$0
	Deep Cleanings	$0
	Extractions	$0
	Root Canals	$0
	Crowns	$0
	Dentures	$0
	Implants	$0

All with **no annual maximum**!

To find an in-network dentist, visit **HFDocFinder.org**. Or if you have questions about CompleteCare dental benefits, call us at **1-888-260-1010** (TTY 1-888-542-3821), 7 days a week, 8am–8pm.

Dental services must be medically necessary; limitations and exclusions apply.

Healthfirst Community Offices

We make it easy for you to contact us—over the phone, online, and in person. Visit one of our convenient community offices, our virtual community office online, and on social media.

Neighborhood Locations Near You

Bronx

Fordham
412 E. Fordham Road

Parkchester
112 Hugh J. Grant Circle

Brooklyn

Bensonhurst
2236 86th Street

Crown Heights
263 Utica Avenue

Flatbush
2166 Nostrand Avenue

Sunset Park
- 5202 5th Avenue
- 5324 7th Avenue

Manhattan

East Broadway
28 E. Broadway

East Harlem
116 E. 116th Street

Washington Heights
1467 St. Nicholas Avenue

Queens

Elmhurst
40-08 81st Street

Flushing
39-06 Main Street

Jackson Heights
93-14 Roosevelt Avenue

Jamaica
161-21 Jamaica Avenue

Richmond Hill
122-01 Liberty Avenue

Ridgewood
56-29 Myrtle Avenue

Long Island

Nassau County

Hempstead
242 Fulton Avenue

Suffolk County

Bay Shore
- South Shore Mall
  1701 Sunrise Highway
- Pronto of Long Island
  128 Pine Aire Drive

Long Island (Continued)

Suffolk County

Patchogue
99 West Main Street

Orange County

Middletown
L & M Multiservices
43 North Street

Newburgh
Crossroads Plaza
50 NY Route 17K

Rockland County

Spring Valley
Panamericana Express Inc.
4 North Main Street

Westchester County

Yonkers
13 Main Street

Go to **healthfirst.org/locations** for a current list of office locations along with our hours of operation, and visit **HFVirtualCommunityOffice.org** to connect with a Healthfirst representative in your area.

Glossary

Ambulatory Surgery Center

A facility that exclusively provides outpatient surgical services to patients not requiring hospitalization and whose expected stay doesn't exceed 24 hours.

Benefit Period

A benefit period begins the day you're admitted as an inpatient at a hospital or skilled nursing facility (SNF). The benefit period ends when you haven't gotten any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

Bone Mass Measurement

Measures bone density to determine whether a patient has osteoporosis (bone disease).

Cardiovascular Screening

Test for heart disease.

Coinsurance

The percentage of costs of a covered healthcare service you pay after you've paid your deductible. Your insurance company pays the rest.

As a member of CompleteCare, you don't have coinsurance for covered services.

Colonoscopy

Medical procedure where a long, flexible, tubular instrument is used to view the entire inner lining of the colon (large intestine) and the rectum.

Copayment (or copay)

A set fee that you pay each time you go to the doctor, get a prescription drug filled, or get other services.

Example: If your health plan has a $10 PCP copayment, you must pay $10 for a checkup with your primary care provider (PCP).

Cost Sharing

The general term for your health expenses, including deductibles, coinsurance, and copayments.

As a member of CompleteCare you don't have cost sharing for covered services.

Covered Service

A service that you're entitled to and which your plan will cover under the terms of your plan. Some cost sharing may apply.

CT

Computed tomography is a medical 3-D imaging technique.

Deductible

The amount of money you must pay (if applicable) in covered expenses each year before your plan or program pays anything for certain covered services. The deductible may not apply to all services.

Example: If your deductible is $500, you need to spend $500 for covered healthcare services within one year before your plan or program will start paying for your health services. Your deductible resets at the beginning of the year. As a member of CompleteCare, you don't have a deductible for covered benefits.

Diabetes Screening

Test for high blood sugar levels.

Dual-Eligible Individual

A person who qualifies for both Medicare and Medicaid coverage.

Effective Date

The date on which your plan coverage begins.

Evidence of Coverage (EOC)

The EOC gives you details about what the plan covers, how much you pay, and more.

Explanation of Benefits (EOB)

A form that you will receive that explains the treatments you and/or a dependent received, the portion of the cost that is covered under your plan, and the amount left that you may have to pay or may have already paid directly to your provider.

Extra Help

Also known as the "Low-Income Subsidy." People who qualify for this program get help paying their plan's monthly premiums, as well as the yearly deductible and copayments for their prescription drugs.

Formulary

A list of prescription drugs (both generic and brand name) covered by your health plan.

This may also be called a list of Part D prescription drugs or Drug List.

Health Maintenance Organization (HMO)

A type of health insurance plan. In most HMOs, you can only go to the hospitals, doctors, and other healthcare providers that have agreements with the plan, except in an emergency. Some HMOs require you to get a referral from your primary care doctor before seeing a specialist. (Healthfirst doesn't require any HMO members to get referrals for in-network specialist care.)

Hospital Affiliation

Shows the hospital(s) where a doctor/provider can treat patients.

In-Network Provider

The doctors and hospitals that are part of the Healthfirst network who provide healthcare to our members.

Inpatient

An inpatient hospital stay is when a doctor admits you into the hospital for treatment.

Mammogram

A diagnostic X-ray of the breast.

Maximum Out-of-Pocket (MOOP)

The annual limit on your out-of-pocket costs for services covered by your plan (i.e., the sum of the deductible, copay, and coinsurance amounts). Once you reach this amount, you don't pay anything for most services. This doesn't include your monthly premium costs, any charges from out-of-network healthcare providers, prescription drugs, or services that aren't covered by the plan.

Remember, Original Medicare doesn't have a MOOP or any cap on spending, so your healthcare expenses can be very high over the course of a year. As a CompleteCare member, you're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most healthcare costs are covered if you qualify for both Medicare and Medicaid.

Medicare Savings Program

A Medicaid program that helps people with limited income and resources pay some or all of their Medicare premiums, deductibles, and coinsurance.

MRI

Magnetic resonance imaging (MRI) uses a strong magnetic field to create detailed images of your organs and tissues.

Network

A group of doctors and hospitals contracted to provide healthcare services to members of a health plan.

Original Medicare

Fee-for-service coverage under which the government pays your healthcare providers directly for your Part A (Hospital) and/or Part B (Medical) benefits.

Out-of-Network Provider

A healthcare provider (doctor or hospital) that is not a part of a plan network. You will typically pay more if you use a provider that isn't in your plan network. Except for emergency and urgent care services, the plan will not cover out-of-network care without a prior authorization.

Outpatient

Medical services that don't require an overnight hospital stay.

Part A

Hospital insurance that helps cover inpatient care in hospitals and inpatient stays in a Skilled Nursing Facility (SNF) (not custodial or long-term care), hospice care services, and home health care services.

Part B

Medical coverage that covers preventive and medically necessary services.

Part C

Medicare Advantage (also known as "Part C") is a type of Medicare health plan offered by a private company that contracts with Medicare. These plans include Part A, Part B, and usually Part D. Plans may offer some extra benefits that Original Medicare doesn't cover.

Part D

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Preauthorization/Precertification (also known as Prior Authorization)

Some healthcare plans, including Healthfirst, require you to check with them before you get certain services. This is to make sure that these healthcare services are necessary and are covered before you get them so that you will not be responsible for the entire cost. Preauthorization is required for many services, but it isn't required in an emergency.

Preferred Provider Organization(PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium

The amount of money some members must pay monthly, quarterly, or twice a year to be covered by a health insurance plan or program. If you're having trouble affording your monthly Part B premium, contact us at 1-877-237-1303 (TTY 1-888-542-3821) to see if you may be eligible for the Medicare Savings Program.

Preventive Care Services

Services you receive from your doctor that help prevent disease or to identify disease while it is more easily treatable. Under Healthcare Reform, most of these services are 100% covered by your insurance plan, which means that you will not have to pay for them.

Primary Care Provider (PCP)

Your primary doctor (also known as a primary care provider or PCP) is the doctor who provides you with basic healthcare and preventive services to help make sure you stay healthy. Your PCP coordinates most of your care, and may refer you to specialists. Your primary care is covered only when you see your PCP, but Healthfirst members may change their PCP at any time by calling Member Services.

Referral

A written order from your primary care doctor for you to see a specialist or get certain services. In many HMOs, you need to get a referral before you can get care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for your care.

With Healthfirst CompleteCare, you can see an in-network specialist without getting a referral from your doctor.

Special Needs Plan (SNP)

Medicare Special Needs Plans are a type of Medicare Advantage Plan designed for certain types of people with Medicare. Some Special Needs Plans are for people with certain chronic diseases and conditions, some are for people who have both Medicare and Medicaid, and some are for people who live in an institution such as a nursing home.

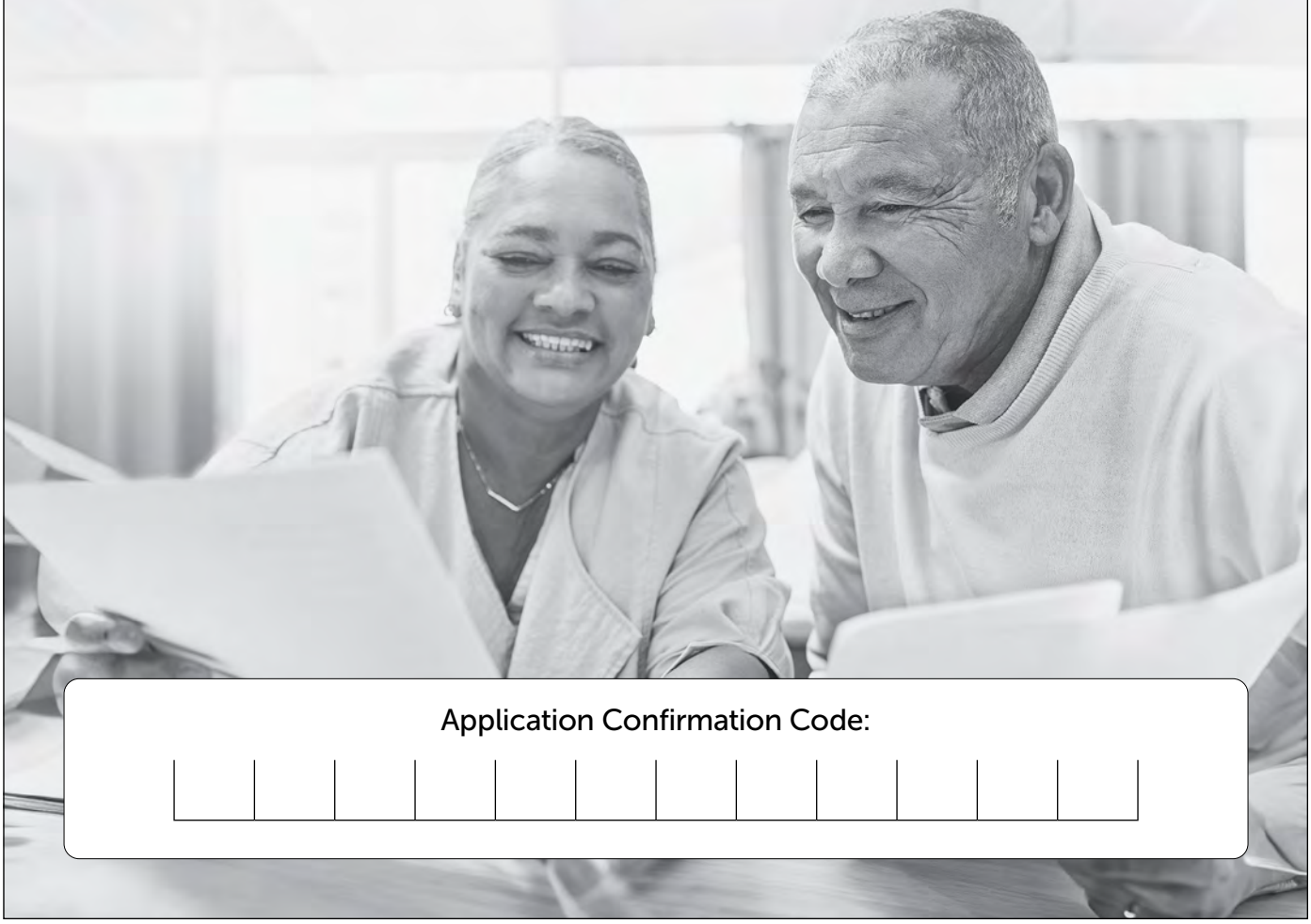
Subsidy

Monetary assistance to help pay health insurance expenses, provided in the form of a refundable tax credit.

healthfirst
Health Insurance for New Yorkers

Enrollment Documents

When you're ready to enroll, your Healthfirst representative will help complete the necessary forms in the next section for you.



Application Confirmation Code:

Scope of Sales Appointment Confirmation Form

healthfirst
Health Insurance for New Yorkers

The Centers for Medicare and Medicaid Services requires agents to document the scope of a marketing appointment prior to any face-to-face sales meeting to ensure both the agent and the Medicare beneficiary (or their authorized representative) understand what will be discussed. All information provided on this form is confidential and should be completed by each person who has Medicare or his/her authorized representative.

Please initial below beside the type of plan(s) you want the agent to discuss.

Medicare Advantage Plans (Part C)

_____ **Medicare Preferred Provider Organization (PPO) –** A type of Medicare Advantage plan available in a local or regional area in which you pay less if you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

_____ **Medicare Health Maintenance Organization (HMO) –** A Medicare Advantage plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can get your care only from doctors or hospitals in the plan's network (except in emergencies).

_____ **Medicare Special Needs Plan (SNP) –** A special type of Medicare Advantage plan that provides more focused and specialized healthcare for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

By signing this form, you agree to a meeting with a sales agent to discuss the types of plans you initialed above. Please note that the person who will discuss the plan(s) is either employed or contracted by a Medicare plan. They do not work directly for the federal government. This person may also be paid based on your enrollment in a plan.

Signing this form does NOT obligate you to enroll in a plan, affect your current or future Medicare enrollment status, or automatically enroll you in a Medicare Advantage plan.

Beneficiary or Authorized Representative Signature and Signature Date:

Signature: _____ Signature Date: _____

If you are the authorized representative, please sign above and print below:

Representative's Name: _____ Relationship to Beneficiary: _____

Scope of Appointment documentation is subject to CMS record retention requirements.
Notes to representative: Yellow copy is for beneficiary and white copy is for Healthfirst records.

To be completed by agent:	
Agent Name:	Agent Phone:
Beneficiary Name:	Beneficiary Phone (Optional):
Beneficiary Address (Optional):	
Initial Method of Contact (indicate here if beneficiary was a walk-in):	
Agent's Signature:	Date Appointment Completed:
Plan(s) the agent represented during this meeting:	
[Plan Use Only:]	

Attestation of Eligibility for an Enrollment Period

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Typically, you may enroll in a Medicare Advantage plan only during the Annual Enrollment Period from October 15 through December 7 of each year. There are exceptions that may allow you to enroll in a Medicare Advantage plan outside of this period. Please read the following statements carefully and check the box if the statement applies to you. By checking any of the following boxes, you are certifying that, to the best of your knowledge, you are eligible for an Enrollment Period. If we later determine that this information is incorrect, you may be disenrolled.

- ☐ I am new to Medicare.
- ☐ I am enrolled in a Medicare Advantage plan and want to make a change during the Medicare Advantage Open Enrollment Period (MA OEP).
- ☐ I recently moved outside of the service area for my current plan or I recently moved and have new options available to me. I moved on (insert date) _____.
- ☐ I recently was released from incarceration. I was released on (insert date) _____.
- ☐ I recently returned to the United States after living permanently outside of the U.S. I returned to the U.S. on (insert date) _____.
- ☐ I recently had a change in my Medicaid (newly got Medicaid, had a change in level of Medicaid assistance, or lost Medicaid) on (insert date) _____.
- ☐ I recently had a change in my Extra Help paying for Medicare prescription drug coverage (newly got Extra Help, had a change in the level of Extra Help, or lost Extra Help) on (insert date) _____.
- ☐ I recently obtained lawful presence status in the United States. I got this status on (insert date) _____.
- ☐ I have Medicare and get full Medicaid benefits. I want to join or switch to a plan that coordinates coverage between my Medicare and Medicaid managed care plans (called an integrated Dual Eligible Special Needs Plan (D-SNP)).
- ☐ I am moving into, live in, or have recently moved out of a Long-Term Care Facility (for example, a nursing home or long-term care facility). I moved/will move into/out of the facility on (insert date) _____.
- ☐ I recently left a PACE program on (insert date) _____.
- ☐ I recently involuntarily lost my creditable prescription drug coverage (coverage as good as Medicare's). I lost my drug coverage on (insert date) _____.
- ☐ I am leaving employer or union coverage on (insert date) _____.
- ☐ I'm in a qualified State Pharmaceutical Assistance Program, or I'm losing help from a State Pharmaceutical Assistance Program.
- ☐ My plan is ending its contract with Medicare, or Medicare is ending its contract with my plan.
- ☐ I was enrolled in a plan by Medicare (or my state) and I want to choose a different plan. My enrollment in that plan started on (insert date) _____.
- ☐ I was enrolled in a Special Needs Plan (SNP) but I have lost the special needs qualification required to be in that plan. I was disenrolled from the SNP on (insert date) _____.
- ☐ I was affected by a weather-related emergency or major disaster (as declared by the Federal Emergency Management Agency (FEMA)). One of the other statements here applied to me, but I was unable to make my enrollment because of the natural disaster.
- ☐ Annual Enrollment Period.
- ☐ Other _____.

If none of these statements applies to you or you are not sure, please contact Healthfirst Medicare Plan at **1-888-260-1010** (TTY users should call 1-888-542-3821) to see if you are eligible to enroll. We are open 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September).

I have reviewed, understand, and agree with the content of this form.

Signature of Applicant: _____ Date: _____

Signature of Licensed Medicare Agent: _____ Date: _____

(Give bottom copy to the applicant; attach original to enrollment form)

Application Confirmation Form (ACF)

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Name of Applicant: _____ Telephone No: _____

Address: _____

I understand that the information I provide in the accompanying Enrollment Request Form will be used to enroll me in a Health Maintenance Organization (HMO) through Healthfirst Medicare Advantage Plan. Yes ☐ No ☐

The Healthfirst licensed Medicare agent/broker explained and I understand that when I enroll in an HMO, I will no longer be able to use my Medicare card to see providers who are not in the Healthfirst network. Instead, I must receive all healthcare services from in-network Healthfirst providers, other than for emergency or urgently needed care. I do not need a referral to go to in-network doctors, specialists, and hospitals. In-network providers include podiatrists, ophthalmologists, chiropractors, and all other specialists, as well as Home Health Aide Agencies. Yes ☐ No ☐

I am currently seeing the following Primary Care Provider (PCP) and Specialist(s):

Provider/Specialist Name	Provider/Specialist ID Number	In Healthfirst Network?		Is Provider:	
Primary Care Provider		☐ Yes	☐ No	☐ Current	☐ New
Specialist		☐ Yes	☐ No	☐ Current	☐ New
Specialist		☐ Yes	☐ No	☐ Current	☐ New
Specialist		☐ Yes	☐ No	☐ Current	☐ New

I am currently receiving care from the following Home Health Aide Agency:

Home Health Aide Agency Name	Agency ID Number	In Healthfirst Network?		Is Agency:	
		☐ Yes	☐ No	☐ Current	☐ New

*By initialing below, I understand that if any of the providers listed above are not in the Healthfirst network, Healthfirst will assign me an in-network PCP so I can receive care. If I choose to see a provider that is not in the Healthfirst network, I understand that neither Healthfirst nor Medicare will pay the bill. I also understand that I will no longer be able to continue to use my Medicare card to see providers that are not in the Healthfirst network. I must use Healthfirst providers and present my Healthfirst Member ID card when receiving care. If I am in an ongoing treatment plan, I may continue to see the provider for a transitional period of up to 90 days by contacting Healthfirst Member Services. *Applicant's Initials _____

If the primary care provider listed above is not in the Healthfirst network, you have the option to choose an in-network PCP yourself and enter their information below:

New In-Network Primary Care Provider (if applicable) _____

Primary Care Provider ID Number _____

I understand that I am applying for coverage in an HMO; I have reviewed, understand, and agree with the content of this form and that I may change in-network providers at any time.

Signature of Applicant or Legal/Authorized Representative: _____ Date: _____

Signature of Licensed Medicare Agent: _____ Date: _____

Signature of Witness: _____ Date: _____

(Give yellow copy to the applicant; attach original to the enrollment form)

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How our licensed agents are paid (Regulation 194 – Disclosure)

Healthfirst's licensed agents are insurance agents (producers) licensed by the state of New York. Healthfirst's licensed agents are authorized to talk with potential enrollees, like you, about our benefits and about the terms and conditions of health insurance contracts.

Our licensed agents may offer advice about the benefits of our health plan and may also enroll beneficiaries. The role of the licensed agent at any meeting usually includes one or more of the activities above.

For Healthfirst Medicare Advantage Plans, Healthfirst pays licensed agents for each member they help enroll in person and who remains in that plan for at least three (3) consecutive months.

If you would like more information about how our licensed agents are paid, please call Member Services at **1-888-260-1010** (Healthfirst Signature (HMO) members call **1-855-771-1081**; Healthfirst Signature (PPO) members call **1-833-350-2910**) (TTY 1-888-542-3821), 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September).

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In-Person Enrollment Acknowledgement Form

My signature below confirms that I, _____ *Insert enrollee name here* _____ ,

met today, _____ *Today's date* _____ , with Healthfirst Sales Representative

_____ *Insert Healthfirst Sales Representative's name here* _____ .

We discussed Healthfirst Medicare Advantage plans, and I enrolled in the following plan:

_____ *Insert plan name here* _____ .

_____ _____ *Date*

Signature of Medicare Beneficiary/Appointed Representative Date

_____

Printed, full name of Medicare Beneficiary/Appointed Representative

Prospect completes form after consenting to the enrollment. Save form for audit purposes.

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Notice to Verify Enrollment in Healthfirst Medicare Plan

Thank you for choosing Healthfirst Medicare Plan.

As part of the enrollment application process, Healthfirst Medicare Plan will confirm your intent to enroll and make sure you understand your new plan.

Healthfirst Medicare Plan will send you an enrollment verification letter within the next 15 days to confirm the Medicare Advantage plan you have chosen. You will get information about your new plan and have the opportunity to call Healthfirst Medicare Plan to ask any questions you may have, on items such as:

- Benefits and services
- Eligibility requirements
- Using providers in our network to get services
- Part D prescription drug benefits and copays (if your plan covers Part D prescription drugs)
- When and how you can switch plans

Notice to Current Healthfirst Medicare Plan Members Switching Plans

If you are currently enrolled with Healthfirst Medicare Plan and are enrolling in a different plan type, you will receive a verification letter as described above.

Thank you,

Healthfirst Medicare Plan

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What to Expect When you Enroll

Today's Date	You can start using your Healthfirst Medicare Advantage plan benefits on:
_____	_____
(Your Application Date)	(Your Plan Start Date)

As a new Healthfirst Medicare Advantage plan member, you will receive important new member materials in the mail over the next few weeks. Use this checklist to help you keep track of each item (delivery times are approximate):

WHEN: Within 10 days

- ☐ **Enrollment and Verification Letter**: Helps you make sure all your enrollment information is correct. Please let us know if any information needs to be updated.

WHEN: Within two weeks

- ☐ **Acknowledgement and Confirmation Letter**: Informs you that Healthfirst has received your application and that Medicare has approved your enrollment. This letter may be used as proof of insurance until you get your Member ID card. It also tells you what your monthly plan premium will be (if applicable) and how to find out if you qualify for extra financial help to pay for your prescription drug costs.

WHEN: Within three weeks

- ☐ **Member ID card**: Present this card at all doctor visits and for prescription refills.
- ☐ **OTC Plus Card** (if applicable): Helps you pay for over-the-counter (OTC) and health-related items, and if your plan allows, healthy foods, home utilities, and more. You must activate this card before using it.
- ☐ **Flex Card** (if applicable): Helps you pay for dental, hearing, and vision out-of-pocket costs, and more. You must activate this card before using it.
- ☐ **Welcome Kit**: Contains important information about your Healthfirst Medicare Advantage plan, such as how to use your benefits and how to view or request copies of your Evidence of Coverage, Drug Formulary (the list of prescription drugs covered by your plan), and more.

You can start using your Healthfirst Medicare Advantage plan benefits on your plan start date. To help you get started, you will get the following within your first few months:

- ☐ **Welcome Phone Calls**: Healthfirst representatives will call you to review your plan details and to answer any questions you may have.
- ☐ **Health Assessment Survey for Healthfirst Medicare Advantage Plan Members**: This short survey helps us get to know you so that we can better support your healthcare needs and goals.

Didn't receive any of these communications?

Call Member Services at **1-888-260-1010**

1-855-771-1081 for Healthfirst Signature (HMO) members

1-833-350-2910 for Healthfirst Signature (PPO) members

(TTY 1-888-542-3821)

7 days a week, 8am–8pm (October through March),
and Monday to Friday, 8am–8pm (April through September)

Medicare Star Ratings

Understanding the Medicare Star Ratings for your Healthfirst Medicare Advantage plan.*

How do Star Ratings work?

The federal government (the Centers for Medicare & Medicaid Services, also known as CMS) uses information from member satisfaction surveys, plans, and healthcare providers to rate Medicare Advantage plans.

Medicare Advantage plans are rated on how well they perform. Each plan receives a rating that ranges from one star (lowest) to five stars (highest). Star Ratings are calculated each year and may change from one year to the next.

If you did not receive a copy of the Medicare Star Ratings from your Healthfirst sales representative along with this booklet, please visit **HFMedicareMaterials.org** or call Healthfirst at **1-888-260-1010** (TTY 1-888-542-3821) to get a copy.

*Every year Medicare evaluates plans based on a 5-star rating system.



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Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. **Healthfirst** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex as defined in 45 CFR § 92.101(a)(2).

Healthfirst provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **Healthfirst** at **1-866-305-0408**. For TTY services, call 1-888-542-3821.

If you believe that **Healthfirst** has not given you these services or has treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with the Vice President, Contact Center Operations by:

- **Mail**: Healthfirst Member Services, P.O. Box 5165, New York, NY 10274-5165
- **Phone**: 1-866-305-0408 (for TTY services, call 1-888-542-3821)
- **Fax**: 1-212-801-3250
- **In person**: Visit a Healthfirst Community Office. Locations and hours are available at Healthfirst.org/CommunityOffices
- **Email**: #cco-vip@healthfirst.org

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

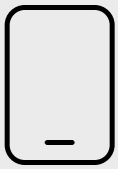
- **Web**: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **Phone**: 1-800-368-1019 (TTY 800-537-7697)
- **Mail**: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
  Complaint forms are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

This notice is available at **Healthfirst's** website: **healthfirst.org**.

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 1-866-305-0408 (TTY: 1-888-542-3821).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 1-866-305-0408 (TTY: 1-888-867-4132).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 1-866-305-0408 (TTY: 1-888-542-3821)。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 1-866-305-0408 (TTY: 1-888-542-3821).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 1-866-305-0408 (TTY: 1-888-542-3821) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 1-866-305-0408 (TTY: 1-888-542-3821).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 1-866-305-0408 (TTY: 1-888-542-3821).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 1-866-305-0408 (TTY: 1-888-542-3821).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 1-866-305-0408 (TTY: 1-888-542-3821).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 1-866-305-0408 (TTY: 1-888-542-3821).	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 1-866-305-0408 (TTY: 1-888-542-3821).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 1-866-305-0408 (TTY: 1-888-542-3821).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 1-866-305-0408 (TTY: 1-888-542-3821) -এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 1-866-305-0408 (TTY: 1-888-542-3821).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 1-866-305-0408 (TTY: 1-888-542-3821).	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 1-866-305-0408 (TTY: 1-888-542-3821).	Urdu

Access Plan Benefits at Your Convenience



Healthfirst NY Mobile App

The Healthfirst NY Mobile App keeps access to healthcare close at hand.

Use the Healthfirst NY Mobile App to find essential services nearby in your community, contact a local rep from a Healthfirst Community Office, view membership information, and more. We're working around the clock to connect you to the care you need, and we look forward to getting new features into your hands.

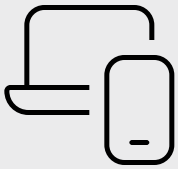
Healthfirst members can:

- Access their digital Member ID card and save, email, or text it.
- Find essential services nearby—food, housing, education, employment, family planning, financial and legal assistance, and more.
- Find pharmacies, retail health clinics, urgent care centers, and other providers.
- Use our Healthfirst Virtual Community Office to search for a local sales rep by borough, office location, language, and gender.
- Access Teladoc Health® to speak with U.S. board-certified doctors 24/7 by phone and video.
- Contact Member Services to get answers to benefit questions.
- Get instant notifications on their device to stay in the know, learn about new features, and more.
- Chat with a Healthfirst representative during business hours.
- Check their OTC Plus card balance.
- Scan OTC item barcodes at participating pharmacies to see if items are covered.

Download on the App Store

GET IT ON Google Play

Apple® compatibility: Requires iOS 13.0 or later. Compatible with iPhone,® iPad,® and iPod touch.® Apple and the Apple logo® are registered trademarks of Apple Inc. Android™ compatibility: Requires Android 8.0 Oreo™ or later. Compatible with phones for Android. Android, Google Play, and the Google Play logo are trademarks of Google LLC.



Healthfirst Member Portal

Access your health benefits 24/7 from your computer or tablet.

Create your Healthfirst account at **MyHFNY.org** to start getting the most out of your benefits today! Whenever you need to find a nearby doctor, specialist, pharmacy, dentist, eye care specialist, hospital, retail health clinic, or urgent care center that's covered under your plan, you can easily find the care you need online.

With your Healthfirst account, you can enjoy 24/7 online access to:

- Search for a doctor, pharmacy, urgent care center, or clinic in our network.
- Access and print many of the forms you need.
- View or print out a temporary Member ID card.
- View recent medical claims and authorizations.
- Review your plan and pharmacy benefits.
- Change your primary care provider (PCP).
- Take an online Annual Health Assessment survey.
- See a complete list of prescription drugs covered under your plan.
- Chat with a Healthfirst representative during business hours.
- Check your OTC Plus card balance.

Plan Highlights

Healthfirst CompleteCare gives you access to a large network of top doctors and hospitals, convenient ways to get care 24/7, and many plan benefits that help you stay healthy, save money, and more.

$0 monthly premium and annual deductible

$0 copays for primary care visits, dental, vision, hearing, 24/7 telemedicine, and more!

Plan benefits include:

A $256/month ($3,072/year) Healthfirst OTC Plus card that features more uses, more places to shop, and more ways to save

Access to the care you need—even after hours
- Retail health clinics, urgent care centers, 24/7 telemedicine, 24/7 Nurse Help Line, and more
- A dedicated Care Team to help you meet your care goals and live independently at home

Dental coverage with no annual maximum
Includes root canals, extractions, dentures, crowns, implants, and more*

Vision and hearing coverage
Includes routine exams, a $400/year supplemental benefit for frames/contacts allowance, and $0 hearing aids

SilverSneakers® Fitness Program with access to gyms and online video workouts

Prescription drug coverage, with convenient delivery options

*Dental services must be medically necessary; limitations and exclusions apply.
No out-of-pocket costs for entry-level hearing aids. Eyewear allowance can only be used at participating retailers.

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healthfirst®
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Healthfirst Representative

_____

Telephone

_____

Email

_____

Questions about this plan?

For answers, visit
HFVirtualCommunityOffice.org or call us at
1-877-237-1303 (TTY 1-888-542-3821)
7 days a week, 8am–8pm



26-5273_EN