This handbook will tell you how to use your Healthfirst plan. Keep this handbook where you can find it when you need it.

January 1–December 31, 2021

**New York**: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Sullivan and Westchester Counties
**Important Phone Numbers**

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<tr>
<th><strong>HEALTHFIRST CORPORATE OFFICE:</strong> 100 Church Street, New York, NY 10007</th>
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| **DentaQuest**  
**Dental**  
- select a primary care dentist  
- inquire about services covered  
- find a dentist’s location  |
| 1-800-508-2047  
Monday to Friday, 8am–8pm |
| **Davis Vision**  
**Vision**  
- inquire about benefit coverage  
- locate participating eye doctors (optometrists and opticians)  |
| 1-800-753-3311  
Monday to Friday, 8am–11pm  
Saturday, 9am–4pm  
Sunday, 12pm–4pm |
| **NationsHearing**  
**Hearing**  
- schedule hearing exams  
- get help purchasing hearing aids  |
| 1-877-438-7251  
Monday to Friday, 8am–8pm |
| **Pharmacy**  
**Prescriptions**  
- submit a pharmacy claim  
- inquire about drug coverage and prescription-related issues  |
| 1-888-260-1010  
(TTY 1-888-542-3821)  
8am–8pm; 7 Days a week  
Oct-Mar; M-F Apr-Sept |

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| **Medicare**  
- 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)  
24 hours a day, 7 days a week |
| **Elderly Pharmaceutical Insurance Coverage Program**  
- 1-800-332-3742 (TTY 1-800-290-9138)  
Monday to Friday, 8am–5pm |

**Local Department of Social Services** *(Please Fill In)*  
Use this space to fill out your and your family’s provider information.

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<th>PCP Name</th>
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<td>Member Name</td>
<td>PCP Name</td>
<td>Phone Number</td>
<td>Address</td>
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**IMPORTANT COMPLETECARE PHONE NUMBERS**

| **Member Services**  
- change your PCP  
- with questions about benefits and services  
- replace an ID card  
- report a birth  
- with referrals  
- enroll in a medical management program  |
| 1-888-260-1010  
(TTY 1-888-542-3821)  
8am-8pm; 7 Days a week  
Oct-Mar; M-F Apr-Sept |
| **New York State Health Dept. (Complaints)**  
- 1-866-712-7197 |
| **New York City - Human Resources Administration (HRA) Medicaid Helpline**  
- 1-888-692-6116 or 1-718-557-1399 |
| **Nassau - Medicaid**  
- 1-516-227-8000 |
| **Orange - Medicaid**  
- 1-845-291-4000 |
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<tr>
<td>Sullivan - Medicaid</td>
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<tr>
<td>Westchester - General Information/Case Management Information Center (CMIC)</td>
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<td>New York Medicaid CHOICE (For Long-Term Care Information)</td>
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<td>New York Medicaid CHOICE (All Other Reasons)</td>
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<td>The Health Insurance Information Counseling and Assistance Program (HIICAP)</td>
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For medical emergencies, please call 911, or go to the nearest emergency room, an urgent care center, or a medical center. You will be asked to present your Healthfirst Member ID card when you receive emergency care.
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1-888-260-1010 | TTY 1-888-542-3821 | MyHFNY.org
WELCOME to Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Plan

Healthfirst CompleteCare (HMO SNP) Medicaid Advantage Plus Plan is for people who have Medicare and full Medicaid, and who need long-term care services.

This handbook tells you about the added benefits you get from CompleteCare. It also tells you how to ask for a specific service, file a complaint, or disenroll from the plan. The benefits in this handbook are in addition to the Medicare benefits in the CompleteCare Medicare Evidence of Coverage (EOC). Keep this handbook together with the EOC. You need both of them to know what services are covered, and how to get them.

Membership Card

Your CompleteCare identification card (Member ID card) will be mailed to you. Carry this card with you at all times. You need to show it to your provider.

Help from Member Services

There is someone to help you at Member Services 7 days a week, 8am–8pm (October through March), and Monday to Friday, 8am–8pm (April through September). Call 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 or online at icannys.org. (TTY users call 711, then follow the prompts to dial 844-614-8800.)

Who is eligible for enrollment in Healthfirst CompleteCare Medicaid Advantage Plus Plan?

You are eligible to enroll in this plan if you meet the following criteria:

- you are age 18 or older.
- are Medicare Part A and B eligible
- Medicaid Community with Long Term Care eligible
- live in the plan’s service area (Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Orange, Queens, Richmond (Staten Island), Rockland, Sullivan, and Westchester counties).
- have a long-term health problem or disability that makes you eligible for nursing home level of care.
- are able to stay at home without jeopard to your health at the time you join the plan.
- are expected to need one or more of the following Community Based Long-Term Care Services (CBLTCS) for more than 120 (one hundred twenty) days from the date that you join the plan:
  - nursing services in the home
  - therapies in the home
  - home health aide services
  - personal care services in the home
  - private duty nursing
  - adult day health care
  - Consumer Directed Personal Assistance Services (CDPAS)

If you are a hospital inpatient, or live in a place licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office for People With Developmental Disabilities (OPWDD), or are enrolled in another managed care plan managed by Medicaid, a Home and Community-Based Services waiver program, or OPWDD Day Treatment Program, or are getting services from hospice, you can enroll with our plan upon discharge or termination.

The coverage explained in this handbook starts on your enrollment date in Healthfirst CompleteCare.
What is the enrollment process for Healthfirst CompleteCare Medicaid Advantage Plus Plan?

Step 1: Confirm Eligibility for long-term care services

People who would like to join Healthfirst CompleteCare and who are new to Community Based Long-Term Care Services must call the Conflict-Free Evaluation and Enrollment Center (CFEEC) at 1-855-222-8350, Monday to Friday, 8:30am–8pm; Saturday, 10am–6pm; or visit www.nymedicaidchoice.com to find out if they are eligible to join. A conflict-free evaluation is only needed if you are new to long-term care services and joining for the first time, or if you have not been enrolled in a plan for 45 (forty-five) days. If you are transferring from a managed long-term care plan (MLTC), mainstream Medicaid, or another Medicaid Advantage Plus (MAP), you are not required to get a CFEEC evaluation.

Step 2: Confirm Eligibility for Medicaid and Medicare

Enrolling in CompleteCare is voluntary. If you want to join, you (or someone on your behalf) can call CompleteCare. Our team will help you contact New York Medicaid Choice to find out more about CompleteCare. If you qualify and have a completed New York Medicaid Choice review, if required, a Healthfirst employee will check your Medicaid eligibility. We will give you a call to provide you with more information about the plan and will schedule a visit for one of our registered nurses to conduct a Community Health Assessment for eligibility to the plan. We will also ask you for information about your healthcare needs.

- Your Medicaid eligibility must be reviewed and approved by the NYC Human Resources Administration or Local Department of Social Services.
- You must have Medicare Parts A and B in order to join CompleteCare.

A licensed representative will schedule a home visit or telephone call and educate you about the product and benefits and help you enroll into CompleteCare using the Medicaid Advantage Plus application.

Step 3: Nurse Assessment

- Our Clinical Eligibility Nurse will conduct a telephonic or home assessment within 30 (thirty) days after you request to enroll in CompleteCare, or from CFEEC’s referral.
- Our Clinical Eligibility Nurse will ask you for verbal consent to let him/her assess your healthcare needs and clinical eligibility.
- Our nurse will ask you to provide verbal consent that lets your healthcare providers give us your medical information, where applicable. In this instance a blank copy will be mailed to your home for a signature to:
  - identify your healthcare needs (also called an “initial assessment”).
  - find out if you are eligible for nursing home level of care.
  - find out if you require community-based long-term care services offered by CompleteCare for a continuous period of more than 120 (one hundred twenty) days.
  - provide and mail you information and a Health Care Proxy form (if you want to assign someone you trust to make healthcare decisions for you).
  - talk about services you may need.

Step 4: Sign Enrollment Agreement

- After the initial assessment, our nurse will ask you to verbally consent to the Enrollment Agreement Transfer Attestation. By providing verbal consent to complete the Enrollment Agreement Transfer Attestation, you agree to:
  - get all covered services from CompleteCare and our network providers.
  - participate in CompleteCare according to the terms and conditions described in this handbook.

Once New York Medicaid Choice and Healthfirst CompleteCare decide that you are eligible to enroll, your Medicaid application will be sent to New York Medicaid Choice (NYMC) and your Medicare application will be sent to Centers for Medicare & Medicaid Services (CMS) for approval.
Your start date will be given to you at the time of enrollment. If the start date changes, Healthfirst CompleteCare will let you know. You will get an enrollment confirmation letter that shows your enrollment date.

After your application is approved, you will get a Member ID card within **10 (ten) calendar days**. If you do not have your Member ID card and need to see a provider, call Member Services to check your coverage. They can fax your information to your provider. You can also use your confirmation of coverage letter as proof of coverage until you get your Member ID card.

During the initial assessment, you will be evaluated by a registered nurse to determine if you meet the clinical eligibility requirements to join CompleteCare. If your clinical assessment determines that you are not eligible to join CompleteCare because of health and safety concerns, we will notify you of the denial of enrollment which will then be sent to NYMC or LDSS for final decision. You will be notified once NYMC or LDSS makes the final decision.

If CMS or NYMC rejects your enrollment, you will get an enrollment denial letter. You can call us at **1-888-260-1010** (TTY 1-888-542-3821) if you disagree with the decision. If NYMC or LDSS rejects your enrollment because you did not meet the eligibility requirements, NYMC or LDSS will tell us. If we disagree with NYMC’s decision, we will follow the dispute resolution process that is approved by the State Department of Health (SDOH). If we do not dispute the rejection or you are found not to meet the standards for enrollment after the dispute process is done, NYMC or LDSS will move on with your denial of enrollment. If you decide to withdraw your enrollment application before the start date of enrollment, Healthfirst CompleteCare will tell NYMC or LDSS of the withdrawal by fax.

**Withdrawal of Enrollment**

Your request for withdrawal must be received the last day of the month prior to the enrollment month. Healthfirst CompleteCare will mail you a cancellation notice.

Long-term care services are no longer covered by New York’s Fee-For-Service (FFS) Medicaid Program.

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You must join a MLTC to get these services. If you need to contact NYMC, please call **1-888-401-6582** (TTY 1-888-329-1541).

**What are my rights and responsibilities as a Healthfirst CompleteCare member?**

As a member of Healthfirst CompleteCare, you have the right to:

- receive medically necessary care.
- timely access to care and services.
- medical record privacy when you get treatment.
- receive information on care choices in a way you want it and in a language you know.
- receive translation services free of charge.
- agree to the care you are getting before the start of treatment.
- be treated with respect and due consideration for your dignity.
- request and receive a copy of your medical records and ask that the records be changed or fixed.
- take part in decisions about your healthcare or refuse treatment.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation as specified in federal regulations on the use of restraints and seclusion.
- get care without regard to sex, gender identity, race, health status, color, age, national origin, sexual orientation, mental or physical disability, marital status, or religion.*
- be told where, when and how to get the services you need from us, such as how you can get covered benefits from out-of-network providers.
- complain to New York State Department of Health (NYSDOH).
- complain to your local department of social services and the right to use the New York State Fair Hearing system and/or a New York State External Appeal where appropriate.
name someone to speak for you about your care and treatment.

■ make advance directives and plans about your care.

■ seek assistance from the Participant Ombudsman program

■ ask for an increase in your services, like your personal care services (PCS) and CDPAS.

*Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on age, sex (such as gender identity or status of being transgender), race, creed, physical or mental disability (such as gender dysphoria), developmental disability, national origin, sexual orientation, type of illness or condition, or the need for health services. If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If you have a disability and need help with access to care, please call Healthfirst Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

Responsibilities of Members

To benefit from enrollment in Healthfirst CompleteCare, you should try to:

■ Participate Actively in Your Care and Care Decisions
  ➤ Speak openly with your provider and Care Team about your health and care.
  ➤ Ask questions to be sure you know, follow, and review your service plan, and take part in your care management calls.
  ➤ Share in care choices and be in charge of your own health.
  ➤ Complete self-care as planned.
  ➤ Keep appointments and let the Care Team know of changes.
  ➤ Use network providers for care except in emergencies.
  ➤ Tell us if you get health services from non-network healthcare providers.
  ➤ Take part in policy development by writing to us, or calling us.
  ➤ Take part in the six-month assessment visit or sooner as needed.

■ Support Healthfirst CompleteCare
  ➤ Tell your Care Team you have concerns about your care or use the Healthfirst CompleteCare appeals and grievances process.
  ➤ Review this Member Handbook and follow the steps to get proper care.
  ➤ Respect the rights and safety of those involved in your care and get help from us to keep your home safe for your care needs.
  ➤ Tell your Care Team the following:
    • if you are leaving the service area
    • if you moved or have a new phone number
    • if you changed providers
    • any changes in a health issue that may affect your current care

Your Right to Use an Advance Directive

You have the right to know your options and make choices about your healthcare.

You have the right to get full information from your providers and other healthcare providers when you go for medical care. Your providers must explain your medical condition and your choices in a way that you can understand.

You also have the right to make choices about your healthcare. To help you, we outlined your rights.

■ Know about all of your choices. You have the right to be told about all of the treatment options for your condition, no matter what they cost or whether they are covered by our plan. This also includes being told about programs to help you safely manage your medications.

■ Know about the risks. You have the right to be told about any risks involved in your care. You must be told if any treatment is part of a research test. You always have the choice of saying no to experimental care.

■ You have the right to say no. You can refuse any care. This includes the right to leave a hospital or other healthcare place, even if your provider advises you not to leave. You also have the right to stop taking your medication. But you will take full responsibility for what happens to your body as a result.
■ Get a coverage denial reason. If you are denied coverage, you have the right to get a reason from us. To get the reason, you will need to ask us for a coverage decision.

You have the right to give orders about what is to be done if you are not able to make healthcare choices for yourself.

Sometimes people become unfit to make healthcare choices for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, if you want to, you can:

■ fill out a written form to give someone the legal power to make healthcare choices for you.

■ give your providers written orders about how you want them to handle your healthcare.

The legal documents that you can use to give your directions before these situations happen are called advance directives. There are many types of advance directives and different names for them. Documents called living will and power of attorney for healthcare are examples of advance directives.

If you want to use an advance directive, here is what to do.

■ Get the form. Get a form from your lawyer, a social worker, or from an office supply store. You can also get advance directive forms from Medicare organizations or from Healthfirst Member Services.

■ Fill it out and sign it. Remember that this is a legal document. Consider having a lawyer help you prepare it.

■ Give copies to the right people. Give copies to your provider and to the person who is making your decisions. You may also want to give copies to close friends or family members. Be sure to keep a copy for yourself.

If you know that you are going to be hospitalized, take a copy with you to the hospital.

■ If you are admitted to the hospital, they will ask you for your signed form.

■ If you have not signed it, the hospital has forms and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive or whether you want to sign one if you are in the hospital. By law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
We Will Treat You with Fairness and Respect at all Times

Healthfirst must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on age, sex (such as gender identity or status of being transgender), race, creed, physical or mental disability (such as gender dysphoria), developmental disability, national origin, sexual orientation, type of illness or condition, or the need for health services.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. If you need to call NY Medicaid Choice, please call 1-888-401-6582 (TTY 1-888-329-1541).

If you have a disability and need help with access to care, please call Member Services at 1-888-260-1010 (TTY 1-888-542-3821). If you have a complaint, Member Services can help.

Transitional Care

New members can get ongoing treatment from a non-network provider for a transitional period of up to 60 (sixty) days from enrollment. The provider must accept our plan rate payment, agree to our policies, and give us your medical information.

If your provider leaves the network, you can get ongoing treatment for a transitional period of up to 90 (ninety) days. The provider must accept our plan rate payment, agree to our policies, and give us your medical information.

Monthly Surplus

The surplus amount is money determined by the New York City Human Resources Administration or Local District of Social Services and under the rules of the medical assistance program that a member must pay monthly to Healthfirst. Members with a surplus will get an invoice on or about the 15th of each month. The amount you pay depends on your eligibility for Medicaid and Medicaid’s monthly surplus program.

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<th>If you are eligible for:</th>
<th>You will pay:</th>
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<tr>
<td>Medicaid (no monthly spend down/ (NAMI))</td>
<td>Nothing to Healthfirst CompleteCare</td>
</tr>
<tr>
<td>Medicaid (with monthly spend down/ (NAMI))</td>
<td>A monthly surplus to Healthfirst CompleteCare as decided by New York City Human Resources Administration/Local District of Social Services</td>
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If you are eligible for Medicaid with a surplus and your surplus changes while you are a Healthfirst CompleteCare member, your monthly payment will be changed.

Money Follows the Person (MFP)/Open Doors

MFP/Open Doors is a program that can help you move from a nursing home back into your community. You can get MFP if you:

- have lived in a nursing home for three (3) months or longer.
- have health needs that can be met through services in your community.

MFP/Open Doors has people called Transition Specialists and Peers who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- giving you information about services and supports in the community.
- finding services offered in the community to help you be independent.
- visiting or calling you after you move to make sure that you have what you need at home.

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.
Services Covered by Healthfirst CompleteCare

Deductibles and Copayments on Medicare Covered Services

Many of the services that you get are covered by Medicare. They are described in the Healthfirst CompleteCare Evidence of Coverage (EOC).

Chapter 3 of the EOC explains the rules for using in-network providers and getting care in a medical emergency or if urgent care is needed. If there are deductibles or copayments for benefits (see Chapter 4 of the EOC, “What is Covered”), we will cover the deductibles and copayments because you have Medicaid.

If there is a monthly premium for benefits (see Chapter 1 of the EOC), you will not have to pay that premium, since you have Medicaid. We will also cover many services that are not covered by Medicare. The sections below explain what is covered.

In-network providers will be paid in full directly by Healthfirst CompleteCare for each service authorized and supplied to you, with no copayment or cost to you. If you get a bill for covered services authorized by us, you are not responsible for paying the bill. Please call your Care Manager. You may be responsible for payment of covered services that were not authorized by us or for covered services that you got from providers out-of-network.

Who is part of my Healthfirst CompleteCare Care Team?

As a member of Healthfirst CompleteCare, you get Care Management Services. You will have a Care Team (CT), which includes a primary care manager (registered nurse or a social worker) and other support staff. The care manager will help you manage your medical and psychosocial and environmental needs. Other members of the support team will be available to assist you in other needs that you may have including but not limited to, arranging appointments and transportation. Your Care Team will work with you and your provider to decide the services you need and make a care plan.

You will have a member of the care team review your care plan at least every six (6) months to make sure your care plan is up to date.

You will get a phone number for the CT. You can call your team with questions or requests. You will get a monthly call from members of your CT, who will ask health-related questions to make sure your care plan is up to date.

What additional services are covered by Healthfirst CompleteCare?

We will arrange and pay for the extra health and social services described below. You can get them as long as needed to stop or treat your illness or disability. Your care manager will help point out the services and providers you need. You may need a referral or an order from your provider for these services, and you must get them from in-network providers.

If you cannot find an in-network provider, you must get approval before using an out-of-network provider, except when it is for a medical emergency or urgently needed care. To get approval for an out-of-network provider, you or your provider must call Healthfirst Utilization Management at 1-888-394-4327 (TTY 1-888-542-3821).

Personal Care

You can get help with one or more activities of daily life: walking, cooking, cleaning, bathing, using the bathroom, personal hygiene, dressing, feeding, nutritional and environment support function tasks. Personal care services need a physician’s order, prior approval, and must be medically necessary.

Consumer Directed Personal Assistance Services (CDPAS)

This program lets you (also known as the “consumer”), or the person acting for you, hire, train, supervise, arrange back-up coverage, keep payroll records, and fire the person giving you personal care
services. You can ask to use the CDPAS program at any time. You can disenroll from the program at any time. Healthfirst will review the level of personal care services, home health aide services, and/or skilled nursing services you need and write you a plan of care.

Once we make your plan of care and tell you how many hours of services are needed, the next step will be for you to find the sufficient number of personal assistants (PAs) needed to perform the services in your plan of care. A PA can be a family member, friend, neighbor, or former aide—but they must be trained to do the work you need. A PA cannot be a person legally in charge of your care (like your spouse or designated representative). The consumer must work with the Healthfirst team to arrange covered services with providers or healthcare agencies.

The consumer is in charge of or responsible for scheduling their PAs. They need to make sure that there is coverage if a PA cannot make it to work. The consumer also needs to keep track of their time worked and sign off on time sheets and other important documents.

Home Health Care Services Not Covered by Medicare

Medicaid-covered home health services include skilled services not covered by Medicare (e.g., physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential, or nurse to pre-fill syringes for disabled people) and/or home health aide services as needed by an approved plan of care. Home health care services not covered by Medicare need a doctor order, prior approval, and must be medically necessary.

Nutrition

Nutrition services include looking at your nutritional needs, food patterns, and planning nutrition fit for your physical, medical, and environmental needs. These services also include education and counseling, and the development of a nutritional treatment plan. Nutritional services need a doctor order, prior approval, and must be medically necessary.

Medical Social Services

Medical social services include checking the need for, arranging for, and providing aid for social problems by a trained social worker. These services will help you with concerns about your illness, finances, housing, or environment. They must be medically necessary before approved by Healthfirst.

Home-Delivered Meals and/or Meals in a Group Setting

You can get meals given to you at home or in another setting (such as an adult home) if you do not have cooking tools or if you have a special need. Meals must be medically necessary before approval by Healthfirst.

Social Day Care

Social day care gives members with limited socialization functions, supervision, monitoring, and nutrition. This program takes place in a safe setting during any part of the day, but for less than a 24-hour period. Other services may include, but are not limited to, personal care help, teaching daily living skills, transportation, caregiver help, and case help. Social day care must be medically necessary before it is approved by Healthfirst.

Non-Emergency Transportation

Healthfirst covers transportation costs for you to get medical care and services. Transportation services are supplied by ambulance, ambulette, taxicab, public transit, or other means fit to your medical condition. An aide can go with you to medical appointments if needed.

Transportation by an approved car service or ambulette services must be arranged by Healthfirst two (2) days before needed. We will send authorization to the transportation vendor. All non-emergency transportation should be arranged by calling 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).
If you do not get pre-approval from Healthfirst for non-emergent transportation, you will be responsible for the full cost. If you take public transportation (i.e., MTA transit, Long Island Rail Road, and/or Metro-North Rail Road, etc.), you must submit a Member Reimbursement Form to Healthfirst to get reimbursed.

This form is on our website at HFMedicareMaterials.org, or you can call Member Services to ask for one. Fill out the form and mail it to the address below. Reimbursement will be mailed to you.

Healthfirst Medicare Plan
Member Services
P.O. Box 5165
New York, NY 10274

Private Duty Nursing

Private duty nursing services are medically necessary services given to you at your permanent or temporary home by a licensed registered professional or licensed practical nurses (RNs or LPNs). The services may be ongoing. Private duty nursing services need a doctor’s order and prior approval.

Non-Medicare Covered Durable Medical Equipment (DME) and Related Supplies

Healthfirst CompleteCare covers any DME covered by Original Medicare. We will not cover specific brands and manufacturers unless your provider asks us and provides medical reason. As a dual-eligible member, you also get Medicaid-covered DME. New York State Medicaid covers additional prosthetics, orthotics, and orthopedic footwear that Medicare doesn’t cover. DME supplies are:

- Medical/Surgical Supplies. Items for medical use other than drugs, which treat a specific condition.
- Medical Equipment. Adaptive devices and equipment prescribed by a healthcare provider.
- Enteral and parenteral nutritional supplements. Liquid nutritional supplements.**
- Prosthetics. Artificial substitute or replacement of a limb.
- Orthotics. Appliances and devices that support or fix a movable part of the body.
- Orthopedic Footwear. Shoes, shoe additions, or braces used to fix, help, or prevent a deformity or range-of-motion issue in a diseased or injured part of the ankle or foot.

Please note: The plan limits incontinence supplies to those manufacturers listed below. We will not cover other incontinence supply brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to Healthfirst CompleteCare and are using a brand of incontinence supplies that is not listed below, we will continue to cover your brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)

Incontinence supplies are limited to Attends, Comfees, Cuties, Comfortwear, Inspire, Covidien, SureCare, and K2 Health.

**Enteral formula limited to nasogastric, jejunostomy, or gastrostomy tube feeding, or treatment of an inborn error of metabolism. Enteral formula and nutritional supplements are limited to people who cannot get nutrition through any other means, and to these conditions: 1) tube-fed people who cannot chew or swallow food and must get nutrition through formula by tube; and 2) people with rare inborn metabolic disorders requiring specific medical formulas to give vital nutrients not available through any other means. Coverage of certain inherited disease of amino acid and organic acid metabolism that include low-protein or modified protein solid food products.

Hearing Services

Members get Medicaid-covered hearing services, such as hearing services and products to ease disability caused by the loss of hearing.

Services include hearing aids, fitting, and dispensing; ear molds and replacement parts; hearing aid checks, evaluations, and repairs; audiology exams and testing; and prescriptions.

Members must get all Medicaid-covered hearing care from providers through NationsHearing. All covered hearing services must be medically necessary but may need prior authorization.
Podiatry

Members get Medicaid-covered podiatry services for medically necessary foot care. This includes care for medical conditions affecting lower limbs; up to four routine foot care visits per year.

Added podiatry benefits include routine foot care for other conditions (up to 12 visits per year) and diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).

Vision

Members get Medicaid-covered vision services as services of optometrists, ophthalmologists, and ophthalmic dispensers such as eyeglasses, medically necessary contact lenses, and polycarbonate lenses, artificial eyes (stock or custom-made), low-vision aids, and low-vision services. Coverage also includes the repair or replacement of parts, examinations for diagnosis and treatment for visual defects and/or eye disease. Medicaid-covered examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Medicaid-covered eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged, or destroyed.

Added vision benefits include one (1) yearly routine eye exam, one (1) yearly glaucoma screening (for those at high risk), and one (1) pair of eyeglasses (standard lenses and frames) every year or up to $175 allowance for eyewear frames from the non-plan frame collection.

Members must get all vision care through Davis Vision. All covered vision services must be medically necessary.

Dental

We offer members dental care through DentaQuest. Covered services include routine dental services such as preventive dental checkups, cleaning, X-rays, fillings, and other services. You do not need a referral from your primary care provider to see a dentist.

How to Access Dental Services:

You must get dental treatment from providers through DentaQuest. All covered dental services must be medically necessary. Individual dental procedures may need pre-approval from DentaQuest.

If you need to find a dentist or change your dentist, call DentaQuest at 1-800-508-2047. They have language services if needed, too.

- Show your Member ID card when you visit your dentist. You will not get a separate dental ID card.

Social/Environmental Supports

Social and environmental supports are services and items that support your healthcare needs and are included in your plan of care. These services and items include but are not limited to: home maintenance tasks, homemaker/chore services, housing improvement, and respite care. Social and environmental supports must be medically necessary before approval by Healthfirst.

Personal Emergency Response Services

Personal Emergency Response Services (PERS) is a personal electronic device that lets high-risk patients get help in an emergency. These devices alert response centers once a “help” button on the device is activated. PERS must be medically necessary before approval by Healthfirst.

Adult Day Health Care

Adult day health care includes: medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities (planned meaningful programs), dental, pharmaceutical, and other ancillary services. Adult day health care needs a physician’s order, prior approval, and must be medically necessary.

Nursing Home Care Not Covered by Medicare (only if you are eligible for institutional Medicaid)

To get nursing home care services not covered by Medicare, the services must follow the treatment plan written by the ordering provider, registered physician assistant, certified nurse practitioner, or certified home health agency. It requires prior approval and must be medically necessary.
Inpatient Mental Healthcare over the 190-day Lifetime Medicare Limit

Inpatient mental health care over the 190 (one hundred ninety)-day lifetime Medicare limit needs a doctor order, prior approval, and must be medically necessary.

Outpatient Mental Health and Substance Abuse

Members can get outpatient mental health and substance abuse services from any in-network provider. You can self-refer for one assessment for each benefit from an in-network provider in a 12 (twelve)-month period. Pre-approval is only needed for out-of-network service requests, electroconvulsive therapy (ECT), and neuropsychological testing.

Outpatient Rehabilitation

In anticipation of a January 1, 2021, start date, Healthfirst CompleteCare (HMO SNP) will remove service limits on physical therapy (PT), occupational therapy (OT), and speech therapy (ST). Instead, Healthfirst CompleteCare (HMO SNP) will cover medically necessary PT, OT, and ST visits that are ordered by a doctor or other licensed professional.

To learn more about these 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).

Can I get care outside of the Service Area?

When you are outside the service area and cannot get care from an in-network provider, we will cover urgently needed care from any provider. These services are non-emergency, unforeseen medical illnesses, injuries, or conditions that require immediate medical care.

You are also covered for emergency care and urgent care worldwide. But Healthfirst will not cover any Part D prescription drugs that you get as part of your emergency or urgent care visit in another country.

Emergency Service

A medical emergency is when you, or someone with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The health symptoms may be a sickness, injury, severe pain, or a medical condition that is quickly getting worse or may cause death.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral.

- **As soon as possible, call Healthfirst about your emergency.**
  - You (or someone else) should call us to tell us about your emergency care within 48 hours. 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).

What is covered if you have a medical emergency?

Emergency medical care is covered whenever you need it, worldwide. This includes ambulance services.

Worldwide emergency/urgent care services, including transportation are subject to a maximum plan benefit allowance of $100,000 per year.

If you have an emergency, we will talk with the providers who are giving you emergency care to help manage and follow up on your care. The providers who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you can get follow-up care. It is covered by the plan. If your emergency care is given by out-of-network providers, we will try to arrange for in-network providers to take over your care.
What if it wasn’t a medical emergency?

If it turns out that your medical emergency was not actually an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care. But after the provider said that it was not an emergency, we will cover additional care only if:

- you go to an in-network provider to get the additional care, or
- the additional care you get is considered urgently needed care, and you follow the rules for getting this urgent care.

Payment of medical emergency services

You can get emergency services from any provider. But when you get emergency or urgently needed care from an out-of-network provider, you should ask the provider to bill the plan.

- If you paid the entire amount yourself when you got the care, you need to send us the bill, along with documentation of any payments you have made.

- You may also get a bill from the provider. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay them.
  - If you have already paid the bill, we will pay you back.

What Services are not covered by Healthfirst CompleteCare?

There are some Medicaid services that the plan does not cover. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) if you have a question about a benefit. Some of the services covered by Medicaid using your Medicaid benefit card include:

- Assisted Living Program

Note: Services are listed in no particular order and may be subject to coverage limitations, exclusions, and exceptions.

- Certain Mental Health Services, including
  - Intensive Psychiatric Rehabilitation Treatment Programs
  - Day Treatment
  - Continuing Day Treatment
  - Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)
  - Assertive Community Treatment (ACT)
  - Partial Hospitalization (not covered by Medicare)
  - Personalized Recovery Oriented Services (PROS)

- Comprehensive Medicaid Case Management

- Directly Observed Therapy for Tuberculosis Disease

- Home and Community Based Waiver Program Services

- Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from Medicare Part D benefit)

- Methadone Maintenance Treatment Programs

- Office for People with Developmental Disability Services

- Out-of-network Family Planning services under the direct access provisions

- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs

Services covered by Original Medicare:

- Hospice services provided to Medicare Advantage members

Services not covered by the plan or by Medicaid

These services are not covered by the plan or by Medicaid:

- Conversion or Reparative Therapy
If you have any questions, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821).

How do I get approval for treatments or services?

Service Authorization Request (also known as Coverage Decision Request)

You have Medicare and get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will not use one process for your Medicare benefits and a different process for your Medicaid benefits. You will usually use one process for both. This is sometimes called an “integrated process” because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 21 for more information on the External Appeals process.

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

When you ask for approval of a treatment or service, it is called a service authorization request (also known as a coverage decision request). To get a service authorization, you or your provider must call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) or write to us at:

Healthfirst Medicare Plan
Utilization Management Department
P.O. Box 5166
New York, NY 10274-5166

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

Which services require prior authorization?

Some covered services require prior authorization (approval in advance) from Healthfirst Utilization Management Department before you get them. You or someone you trust can ask for prior authorization. The following treatments and services must be approved before you get them:

- Elective (non-emergency) inpatient admissions
- Residential health care facility care
- Home health care
- Personal care services
- Personal Emergency Response System (PERS)
- Adult and Social Day Care
- Nutritional Services
- Social and environmental services (chore services, home modifications or respite)
- Durable medical equipment (DME)
- Inpatient mental health care
- Bunionectomy and hammer toe repair
- Partial hospitalization services
- Outpatient surgery, if cosmetic
- Non-emergency transportation, including ambulance services
- Prosthetic devices and related supplies
- Outpatient diagnostic tests and therapeutic services – (i.e., PET scans and radiation therapy)
- Comprehensive Dental Services
- Private Duty Nursing
- Consumer Directed Personal Assistance (CDPAS)

Concurrent Review

You can also ask Healthfirst Utilization Management Department to get more of a service than you are getting now. This is called concurrent review.

Retrospective Review

Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called retrospective review. We will tell you if we do these reviews.
What happens after we get your service authorization request

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

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

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

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

Standard Process

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

- A standard review for a prior authorization request means we will give you an answer within 3 work days of when we have all the information we need, but no later than 14 calendar days after we get your request. If your case is a concurrent review where you are asking for a change to a service you are already getting, we will make a decision within 1 work day of when we have all the information we need, but will give you an answer no later than 14 calendar days after we get your request.

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

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

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

- If our answer is yes to part or all of what you asked for, we will authorize the service or give you the item that you asked for.

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

Fast Track Process

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

- A fast review of a prior authorization request means we will give you an answer within 1 work day of when we have all the information we need but no later than 72 hours from when you made your request to us.

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

- If you believe we should not take extra days, you can file a “fast complaint.” (For more information about the process for making complaints, see What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period) you can file an appeal. See Level 1 Appeals below for how to make an appeal.

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

1) You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care you already got.)

2) Using the standard deadlines could cause serious harm to your life or health, or hurt your ability to function.

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

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

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

This letter will tell you that if your provider asks for the fast service authorization, we will automatically give a fast service authorization.

- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see What To Do If You Have A Complaint About Our Plan later in this chapter.)

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

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

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

If we are changing a service you are already getting

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.

- If we are checking care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.

You may also have special Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending. For more information about these rights, refer to Chapter 9 of the Healthfirst CompleteCare (HMO SNP) Evidence of Coverage.
What To Do If You Want To Appeal A Decision About Your Care

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

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see below).

- Healthfirst CompleteCare can also explain the complaints and appeals processes available to you depending on your complaint. You can call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) to get more information on your rights and the options available to you.

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

Level 1 Appeals (also known as a Plan Level Appeal)

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

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

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

You can file a Level 1 Appeal:

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

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have 60 days from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.

- If you are appealing a decision we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a “fast appeal.”

  ➤ The requirements and procedures for getting a “fast appeal” are the same as for getting a “fast track service authorization.” To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in the Fast Track Process section above.)

  ➤ If your provider tells us that your health requires a “fast appeal,” we will give you a fast appeal.

  ➤ If your case was a concurrent review where we were reviewing a service you are already getting, you will automatically get a fast appeal.
You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) if you need help filing a Level 1 Appeal.

➤ Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an “Appointment of Representative” form, or write and sign a letter naming your representative.

- To get an “Appointment of Representative” form, call Member Services and ask for the form. You can also get the form on the Medicare website at [https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at healthfirst.org/medicare. The form gives the person permission to act for you. You must give us a copy of the signed form; OR
- You can write a letter and send it to us. (Your or the person named in the letter as your representative can send us the letter.)

We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.

You can make the Level 1 Appeal by phone or in writing.

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

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

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

We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action, whichever is later.

If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.

Note: If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records used to make and support our appeal decision. The case file serves as the evidence packet that Healthfirst will provide to the independent review organization for Administrative hearing and External appeals.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-888-260-1010 (TTY 1-888-542-3821) if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will automatically send your case on to the next level of the appeals process.
Timeframes for a “standard” appeal

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

➤ If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.

➤ For more information about the process for making complaints, including fast complaints, see What To Do If You Have A Complaint About Our Plan, below, for more information.

- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
  ➤ An independent outside organization will review it.
  ➤ We talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is yes to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- If our answer is no to part or all of what you asked for, to make sure we followed all the rules when we said no to your appeal, we are required to send your appeal to the next level of appeal. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a “fast” appeal

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

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

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

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

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

At any time in the process you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.
Level 2 Appeals

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

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

- The Hearing Office is an independent New York State agency. It is not connected with us. Medicare and Medicaid oversee its work.

- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a free copy of your case file.

- You have a right to give the Hearing Office additional information to support your appeal.

- Reviewers at the Hearing Office will take a careful look at all of the information related to your appeal. The Hearing Office will contact you to schedule a hearing.

- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it gets your appeal.

- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 18 for information about continuing your benefits during Level 1 Appeals.

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

- If you had a standard appeal to our plan at Level 1, you will automatically get a standard appeal at Level 2.

- The review organization must give you an answer to your Level 2 Appeal within 90 calendar days of when it gets your appeal.

- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

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

- If the Hearing Office says yes to part or all of your request, we must authorize the service or give you the item within one business day of when we get the Hearing Office’s decision.

- If the Hearing Office says no to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision” or “turning down your appeal.”)

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

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).

- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.

- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.

- The decision you get from the Medicare Appeals Council related to Medicaid benefits will be final.

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

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

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

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

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

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan’s Final Adverse Determination; or

- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); or

- You and the plan may agree to skip the plan’s appeals process and go directly to External Appeal; or

- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

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

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

- You can call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) if you need help filing an appeal.

- You and your doctors will have to give information about your medical problem.

- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882

- Go to the Department of Financial Services’ website at www.dfs.ny.gov

- Contact the health plan at 1-888-260-1010 (TTY 1-888-542-3821)

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

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

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of Health by calling 1-866-712-7197.
What To Do If You Have A Complaint About Our Plan

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

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821) or write to Member Services. The formal name for “making a complaint” is “filing a grievance.”

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

How to File a Complaint:

- Usually, calling Member Services is the first step. If there is anything else you need to do, Member Services will let you know. Call 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).

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

- The member can call us and we take their complaints over the phone.

  ➤ We acknowledge receipt of complaint via writing if the member issue was not resolved the same day.

  ➤ After investigation of the complaint, a resolution letter will be sent to the member.

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

What happens next:

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

- We answer most complaints in 30 calendar days.

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

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

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

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

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

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

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

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

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

How to make a complaint appeal:

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

What happens after we get your complaint appeal:

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

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

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

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

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

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

Disenrollment from Healthfirst CompleteCare

Termination of Benefits from Voluntary Disenrollment

Enrollment in CompleteCare is voluntary. You can disenroll at any time. We will work with you and/or your representative to make a safe and smooth transfer to an alternate Medicaid Advantage Plus Plan.

- To initiate disenrollment, your or your designee must call or write to us.
- You can ask any member of your Care Team to help you with the process.
- If you continue to need services, such as personal care, your Care Team can help you call New York Medicaid Choice at 1-888-401-6582. You can also call them directly to join another Managed Long Term Care plan or waiver service to continue getting community based long-term care services.
- You will get written notice upon receipt of your request to disenroll. It will be effective no later than the first day of the second month after the month you requested disenrollment.

*You must be enrolled in an MLTC plan or waiver program to continue getting CBLTC services, as Medicaid Fee-For-Services does not provide these services.

During the Annual Enrollment Period (AEP) (that runs from October 15 through December 7 each year), you may disenroll from Healthfirst CompleteCare and

1-888-260-1010 | TTY 1-888-542-3821 | MyHFNY.org
enroll in a Medicaid Advantage Plus plan. You can also return to Original Medicare and be disenrolled from our plan.

- We will send you written notice of your disenrollment. It will be effective January 1 of the following year, or at the end of the month when you completed a request.

- If you did not want to disenroll from our plan, you will need to contact us to cancel your disenrollment before the last day of the month when you are scheduled to be disenrolled.

- You may disenroll by faxing or submitting a signed written notice to Healthfirst CompleteCare. You can also call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week, or visit www.medicare.gov.

During the Medicare Advantage Open Enrollment Period (MA OEP) (that runs from January 1 through March 31 each year):

- You may add or drop Part D coverage. You may either switch to Medicaid Advantage Plus, Medicare Advantage-only, or Original Medicare (with or without a stand-alone Part D plan).

- The start date for disenrollment would be the end of the month when you made a completed request.

If you get medical assistance from the New York State Department of Health (NYSDOH) and Extra Help for Part D drugs from Medicare:

- You can disenroll once during each of the following time periods (known as Special Enrollment Periods (SEPs)):
  - January–March
  - April–June
  - July–September

- Your disenrollment would be effective with the start of the new month.

- You may disenroll by writing to Healthfirst CompleteCare or by joining another Medicaid Advantage Plus plan.

- If you qualify for other SEPs, when you use that option to join another Medicaid Advantage Plus Plan, you will automatically be disenrolled from our plan.

If you are enrolled in Healthfirst CompleteCare and you apply to get services from another MLTC plan or a Home and Community Based Services waiver program, an Office for People with Developmental Disabilities Day Treatment program, you are considered to have initiated disenrollment from our plan.

Involuntary Disenrollment

There are certain circumstances when Healthfirst CompleteCare will disenroll you from our plan. Before taking this step, we will try to resolve the issues/concerns if possible. You will get a written notice when we decide to start the involuntary disenrollment process.

- If you are being involuntarily disenrolled, you will need to choose another MLTC plan or waiver service to continue to receive your long-term care services. If you do not choose a new plan, you will be assigned to a new plan by New York Medicaid Choice (NYMC).

- Once your disenrollment is approved by New York Medicaid Choice (NYMC), LDSS, or entity designated by the NYSDOH, you will get a notice of your right to a Fair Hearing. We will send you written notice confirming your disenrollment.

- Healthfirst CompleteCare must disenroll you if any of the following are true. This is called an involuntary disenrollment, that we must initiate within five (5) business days from the date we become aware of any of the following.
  - You move out of the Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Orange, Queens, Richmond (Staten Island), Rockland, Sullivan, or Westchester County.
  - You leave the Bronx, Kings (Brooklyn), Nassau, New York (Manhattan), Orange, Queens, Richmond (Staten Island), Rockland, Sullivan, or Westchester County for any reason for more than thirty (30) days with or without telling us.
➤ You lost your benefits rights from the Medicaid program and did not regain those benefits within your 90 (ninety) days grace period.

➤ You are no longer eligible for Medicare benefits.

➤ You are not eligible for MLTC because you are assessed as no longer demonstrating a functional or clinical need for the authorization and delivery of any community-based long-term care services on a monthly basis or, for non-dual eligible enrollees who no longer meet the nursing home level of care as determined using the assessment tool prescribed by the Department. If your sole service is identified as Social Day Care, you will be disenrolled from the MLTC plan. CompleteCare will provide LDSS or entity designated by the Department, the result of its assessment and recommendations regarding disenrollment within **five (5) business days** of making such determination.

➤ You do not need or get at least one of these CBLTCS services in each calendar month:
  - Nursing services in the home
  - Therapies in the home
  - Home health aide services
  - Personal care services in the home
  - Adult day health care
  - Private duty nursing
  - Consumer Directed Personal Assistance Services

➤ You are incarcerated. The disenrollment date will be the first day of the month following the incarceration.

➤ You become homeless and your current shelter does not allow for home care services.

➤ You fail to pay or make arrangements to pay any amount owed as Medicaid surplus within **thirty (30) days** after the amount first became due. And, during this time, we tried to collect the amount, made a written demand for payment, and told you in writing about the possibility of disenrollment.

➤ You, or your family members or caregivers, engage in conduct or behavior that seriously harms our ability to provide services to you or others.

➤ You provided untrue information on the enrollment form or allowed another person to use your enrollment card and benefits.

➤ You fail to complete and submit any necessary consent or release forms.

Healthfirst CompleteCare cannot disenroll you because of a harmful change in your health status, or because of your utilization of medical services, your diminished mental capacity, or uncooperative or disruptive behaviors resulting from your medical condition or special needs.

**Effective Date of Disenrollment and Coordination of Transfer to Other Service Providers**

➤ Your disenrollment will be effective on the last day of the month after it is processed by NYMC, LDSS, or entity designated by NYSDOH.

➤ Until your disenrollment becomes effective, Healthfirst CompleteCare will continue to provide covered services according to your Person Centered Service Plan (PCSP). Your Care Team can help you identify other service providers who can meet your care needs. We will assist you in calling these providers and will coordinate the transfer of your care to them.

**Re-Enrollment Provisions**

If you voluntarily disenroll, you will be allowed to re-enroll in Healthfirst CompleteCare as long as you meet our enrollment eligibility standards. If you have been involuntarily disenrolled, you may be allowed to re-enroll in the plan if the circumstances that were the basis for disenrollment have been resolved.
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.

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 treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Healthfirst 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: 100 Church Street, New York, NY 10007
- Email: http://healthfirst.org/members/contact/

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
- 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
- Phone: 1-800-368-1019 (TTY 800-537-7697)
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<thead>
<tr>
<th>Language</th>
<th>Text</th>
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<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).</td>
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<tr>
<td>Arabic</td>
<td>متى أن كنت تتحدث العربية، فسوف تتوفر خدمات المساعدة اللغوية لك بالمجمل. اتصل برقم 0808 1-866-305-0408 (TTY: 1-888-542-3821)</td>
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<td>Yiddish</td>
<td>אירופאָןש אַ דאָדע אָידיש. גענען אירופהָןש פראַה אָיקר אירופהָןש הילפֿ פּרָוי פּוזן (TTY: 1-888-542-3821) 1-866-305-0408</td>
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<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولنے بیان، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب بیان کے ہوئے (TTY: 1-888-542-3821) 1-866-305-0408</td>
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Community Offices Near You

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<tr>
<th>BRONX</th>
<th>QUEENS</th>
<th>LONG ISLAND (continued)</th>
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<tr>
<td>East Tremont</td>
<td>Elmhurst</td>
<td>SUFFOLK COUNTY</td>
</tr>
<tr>
<td>774 E. Tremont Avenue (between Prospect and Marmion Avenues)</td>
<td>40-08 81st Street (between Roosevelt and 41st Avenues)</td>
<td>Bay Shore</td>
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<td>longfield South Shore Mall 1701 Sunrise Highway (in the JCPenney Wing)</td>
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<td>Fordham</td>
<td>Flushing</td>
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<td>412 E. Fordham Road (entrance on Webster Avenue)</td>
<td>41-60 Main Street Rooms 201 &amp; 311 (between Sanford and Maple Avenues)</td>
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<td>BROOKLYN</td>
<td>Main Plaza Mall</td>
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<td>Bensonhurst</td>
<td>37-02 Main Street (between 37th and 38th Avenues)</td>
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<tr>
<td>2236 86th Street (between Bay 31st and Bay 32nd Streets)</td>
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<td>Flatbush</td>
<td>Jackson Heights</td>
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<tr>
<td>2166 Nostrand Avenue (between Avenue H and Hillel Place)</td>
<td>93-14 Roosevelt Avenue (between Whitney Avenue and 94th Street)</td>
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<tr>
<td>Sunset Park</td>
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<td>5324 7th Avenue (between 53rd and 54th Streets)</td>
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<td>MANHATTAN</td>
<td>Jamaica</td>
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<td>Chinatown</td>
<td>Jamaica Colosseum Mall 89-02 165th Street, Main Level (between 89th and Jamaica Avenues)</td>
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<tr>
<td>128 Mott Street, Room 407 (between Grand and Hester Streets)</td>
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<tr>
<td>28 E. Broadway (between Catherine and Market Streets)</td>
<td>Richmond Hill</td>
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<tr>
<td>Harlem</td>
<td>122-01 Liberty Avenue (between 122nd and 123rd Streets)</td>
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<td>34 E. 125th Street (corner of 125th Street and Madison Avenue)</td>
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<tr>
<td>Washington Heights</td>
<td>Green Acres Mall 2034 Green Acres Mall Sunrise Highway, Level 1 (in the Kohl’s Wing)</td>
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<tr>
<td>1467 St. Nicholas Avenue (between W. 183rd and W. 184th Streets)</td>
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Community office locations subject to change. For the most up-to-date locations, please visit healthfirst.org/locations.
For questions about CompleteCare (HMO SNP) benefits, call Member Services at 1-888-260-1010 (TTY 1-888-542-3821), 8am-8pm: 7 Days a week Oct-Mar; M-F Apr-Sept. To access your secure Healthfirst account, visit us at MyHFNY.org. We're mobile-optimized, so you can use your smartphone or any mobile device!

Coverage is provided by Healthfirst Health Plan, Inc. Healthfirst Health Plan, Inc. is an HMO plan with a Medicare contract and a contract with the New York Medicaid program. Enrollment in Healthfirst Medicare Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums, and/or copayments/coinsurance may change on January 1 of each year. Medicare Part B premium is covered for dual-eligible members with full Medicaid coverage. This plan is available to anyone who has full Medicaid benefits from the State and Medicare. Eligible beneficiaries can enroll at any time. Contact Healthfirst CompleteCare (HMO SNP) for additional information. This handbook is available in English, Spanish, and Chinese. Este manual está disponible en inglés, español y chino. 本手冊可用英文、西班牙文與中文提供。