2019 Evidence of Coverage
CompleteCare (HMO SNP)
New York City, and Nassau and Westchester Counties
January 1, 2019–December 31, 2019
Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Healthfirst CompleteCare (HMO SNP)

This booklet gives you the details about your Medicare and Medicaid health care, long-term care, home and community-based services, and prescription drug coverage from January 1 – December 31, 2019. It explains how to get coverage for the health care services and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

This plan, Healthfirst CompleteCare, is offered by Healthfirst Health Plan, Inc. dba Healthfirst Medicare Plan. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Healthfirst Medicare Plan. When it says “plan” or “our plan,” it means Healthfirst CompleteCare.)

Healthfirst Health Plan, Inc., dba Healthfirst Medicare Plan, 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 document is available for free in Spanish and Chinese. Please contact our Member Services number at 1-888-260-1010 for additional information (TTY users should call 1-888-542-3821). Hours are 7 days a week from 8am-8pm.

Este documento está disponible de forma gratuita en español, y chino. Por favor, comuníquese con nuestro número de Servicios a los Miembros al 1-888-260-1010 para información adicional. Los usuarios de TTY deben llamar al 1-888-867-4132. Horario de atención los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.

• 本文件有西班牙文及中文版本供免費索取。如需更多資訊，請聯絡我們的會員服務部，電話號碼是1-888-260-1010。 （聽力語言障礙服務用戶請致電TTY 1-888-542-3821）。服務時間每週七天，每天上午8時至晚上8時

This information is available in a different format, including Braille and large print. Please call Member Services at the number listed above if you need plan information in another format or language.

Benefits, premium, deductible, and/or copayments / coinsurance may change on January 1, 2020.

The formulary, pharmacy network, and provider network may change at any time. You will receive notice when necessary.
2019 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

Chapter 1. Getting started as a member ........................................................ 2

Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources .......................... 18

Tells you how to get in touch with our plan (Healthfirst CompleteCare Plan) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3. Using the plan’s coverage for your medical and other covered services ................................................................. 41

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.

Chapter 4. Benefits Chart (What is covered) ........................................ 58

Gives the details about which types of medical care are covered and not covered for you as a member of our plan.

Chapter 5. Using the plan’s coverage for your Part D prescription drugs ......................... 115

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan’s List of Covered Drugs (Formulary) to find out which drugs are covered. Tells which kinds of drugs are not covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan’s programs for drug safety and managing medications.
Chapter 6. What you pay for your Part D prescription drugs .......... 141

Tells about the four (4) stages of drug coverage (Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs.

Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs ........................................................ 159

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

Chapter 8. Your rights and responsibilities .............................................. 167

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints) ...................... 181

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.

- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 10. Ending your membership in the plan ................................. 262

Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 11. Legal notices ............................................................................. 272

Includes notices about governing law and about nondiscrimination.

Chapter 12. Definitions of important words ............................................. 286

Explains key terms used in this booklet.
CHAPTER 1

Getting started as a member
Chapter 1. Getting started as a member

SECTION 1 Introduction ........................................................................................................... 4
Section 1.1 You are enrolled in Healthfirst CompleteCare, which is a specialized Medicare Advantage Plan (Special Needs Plan) ........... 4
Section 1.2 What is the Evidence of Coverage booklet about? ......................... 5
Section 1.3 Legal information about the Evidence of Coverage ................. 5

SECTION 2 What makes you eligible to be a plan member? ......................... 6
Section 2.1 Your eligibility requirements ............................................................. 6
Section 2.2 What are Medicare Part A and Medicare Part B? ..................... 7
Section 2.3 What is Medicaid? ................................................................. 7
Section 2.4 Here is the plan service area for Healthfirst CompleteCare .......... 7
Section 2.5 U.S. Citizen or Lawful Presence .............................................. 8

SECTION 3 What other materials will you get from us? ......................... 8
Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs .......................................................... 8
Section 3.2 The Provider/Pharmacy Directory: Your guide to all providers and pharmacies in the plan’s network ........................................ 9
Section 3.3 The plan’s List of Covered Drugs (Formulary) ......................... 10
Section 3.4 The Part D Explanation of Benefits (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs ....................................................... 11

SECTION 4 Your monthly premium for Healthfirst CompleteCare .......... 11
Section 4.1 How much is your plan premium? .......................................... 11
Section 4.2 There are several ways you can pay your plan premium ........... 13
Section 4.3 Can we change your monthly plan premium during the year? .... 14
SECTION 5  Medicaid Monthly Spend-down (Surplus Income) for Healthfirst CompleteCare ........................................................... 14
Section 5.1  Monthly spend-down payment ........................................................ 14

SECTION 6  Please keep your plan membership record up to date ............ 15
Section 6.1  How to help make sure that we have accurate information about you ................................................................. 15

SECTION 7  We protect the privacy of your personal health information... 16
Section 7.1  We make sure that your health information is protected ............... 16

SECTION 8  How other insurance works with our plan ....................... 16
Section 8.1  Which plan pays first when you have other insurance? .......... 16
SECTION 1 Introduction

Section 1.1 You are enrolled in Healthfirst CompleteCare, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).

- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, Healthfirst CompleteCare.

There are different types of Medicare health plans. Healthfirst CompleteCare is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Healthfirst CompleteCare is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

**Coverage under this Plan qualifies as** Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

Because you get assistance from Medicaid, with your Medicare Part A and B cost-sharing (deductibles, copayments, and coinsurance) you may pay nothing for your Medicare health care services. Medicaid also provides other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive “Extra Help” from Medicare to pay for the costs of your Medicare prescription drugs. Healthfirst CompleteCare will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Healthfirst CompleteCare is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the New York Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage, long term care, and home and community-based services.
Section 1.2 What is the Evidence of Coverage booklet about?

This Evidence of Coverage booklet tells you how to get your Medicare and Medicaid medical care, long-term care, home and community-based services, and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care, long-term care, home and community-based services, and prescription drugs available to you as a member of Healthfirst CompleteCare.

It’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact our plan’s Member Services (phone numbers are printed on the back of this booklet).

Section 1.3 Legal information about the Evidence of Coverage

It’s part of our contract with you

This Evidence of Coverage is part of our contract with you about how Healthfirst CompleteCare covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Healthfirst CompleteCare between January 1, 2019 and December 31, 2019.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Healthfirst CompleteCare after December 31, 2019. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2019.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve Healthfirst CompleteCare each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.
SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B (section 2.2 tells you about Medicare Part A and Medicare Part B)
- --and-- You live in our geographic service area (section 2.4 below describes our service area)
- --and— you are a United States citizen or are lawfully present in the United States
- -- and -- You do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- and -- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) You cannot be eligible for full Medicaid benefits if you are only enrolled in the following programs: Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), or Qualifying Individual-1 (QI1). To be eligible for our plan you must be eligible for Medicare and Full Medicaid Benefits.

Please note: If you lose your Medicaid eligibility but can reasonably be expected to regain eligibility within 3 months, then you are still eligible for membership in our plan (Chapter 4, section 2.1 tells you about coverage during a period of deemed continued eligibility).

In addition, you must:

1) Be 18 years of age or older
2) Reside in the plan’s service area (Bronx, Kings, Nassau, New York, Queens, Richmond and Westchester Counties)
3) Have a chronic illness or disability that makes you eligible for a nursing home level of care
4) Need one or more of the following services for more than 120 days from the date that you join our plan:
   - Nursing services in the home
   - Therapies in the home
   - Home health aide services
   - Personal care services in the home
   - Adult day health care,
Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 What is Medicaid?

Medicaid is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments) plus full Medicaid benefits.
- **Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Helps pay Part B premiums plus full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** Helps pay Medicare Part B premiums, in some cases Medicare Part A premiums and full Medicaid benefits.

Section 2.4 Here is the plan service area for Healthfirst CompleteCare

Although Medicare is a Federal program, Healthfirst CompleteCare is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.
Our service area includes these counties in New York: Bronx, Kings, Nassau, New York, Queens, Richmond and Westchester. If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.5 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Healthfirst CompleteCare if you are not eligible to remain a member on this basis. Healthfirst CompleteCare must disenroll you if you do not meet this requirement.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Here’s a sample membership card to show you what yours will look like:

As long as you are a member of our plan, in most cases, you must not use your new red, white, and blue Medicare card to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your new Medicare card if you need hospital services. Keep your new red, white, and blue Medicare card in a safe place in case you need it later.
Here’s why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Healthfirst CompleteCare membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back of this booklet.)

Some benefits are only covered by New York State Fee-For-Service Medicaid, and not Healthfirst CompleteCare. You will need to use your New York State issued Medicaid Card when accessing the services that are only covered by New York State Fee-For-Service Medicaid.

Section 3.2 The Provider/Pharmacy Directory: Your guide to all providers and pharmacies in the plan’s network

The Provider/Pharmacy Directory lists our network providers and durable medical equipment suppliers. The directory also includes participating Medicaid providers, which are marked by a star in the Provider/Pharmacy Directory.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, community health centers and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at www.HFDocFinder.org.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Healthfirst CompleteCare authorizes use of out-of-network providers and when accessing additional benefits and services covered exclusively by Medicaid using your New York State issued Medicaid identification card. See Chapter 3 (Using the plan’s coverage for your medical and other covered services) for more specific information about emergency, out-of-network, and out-of-area coverage.

To find network providers who also accept New York State Medicaid, look for the Medicaid indicator next to the provider’s name in the Provider/Pharmacy Directory.
If you don’t have your copy of the *Provider/Pharmacy Directory*, you can request a copy from Member Services (phone numbers are printed on the back of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also view and search the *Provider/Pharmacy Directory* at www.HFMedicareMaterials.org. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

**What are “network pharmacies”?**

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

**Why do you need to know about network pharmacies?**

You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.HFDocFinder.org. You may also call Member Services for updated provider information or to ask us to mail you a *Provider/Pharmacy Directory*. **Please review the 2019 Provider/Pharmacy Directory to see if which pharmacies are in our network.**

If you don’t have the *Provider/Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.HFDocFinder.org.

### Section 3.3 The plan’s List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Healthfirst CompleteCare. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare and Medicaid. Medicare and Medicaid have approved the Healthfirst CompleteCare Drug List.

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Healthfirst CompleteCare Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.HFMedicareMaterials.org) or call Member Services (phone numbers are printed on the back of this booklet).
When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back of this booklet).

**SECTION 4**

Your monthly premium for Healthfirst CompleteCare

**Section 4.1 How much is your plan premium?**

For 2019, the monthly premium for Healthfirst CompleteCare is $39.30. In addition, you must continue to pay your Medicare Part B premium. However, because you are a dual eligible Special Needs Plan member with Full Medicaid Benefits, your Medicare Part B premium is covered on your behalf by New York State Medicaid. In addition, you also qualify for Medicare’s “Extra Help,” which provides assistance in covering the cost of prescription drug coverage, including the cost of your monthly Part D plan premium of $39.30, so you pay $0.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a Part D late enrollment penalty because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
If you receive “Extra Help” from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty,

If you ever lose your low income subsidy "Extra Help", you would be subject to a Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage.

Some members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Healthfirst CompleteCare members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

Some people pay an extra amount for Part D because of their yearly income; this is known as Income Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. If you had a life-changing event that caused your income to go down, you can ask Social Security to reconsider their decision.
- If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan.
- You can also visit https://www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of Medicare & You 2019 gives information about these premiums in the section called “2019 Medicare Costs.” Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2019 from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
Section 4.2 There are several ways you can pay your plan premium

There are three (3) ways you can pay your plan premium. We will send you a bill each month which explains your options for making your premium payments to us. You can also call Member Services to request a change to how you pay your monthly premiums, or to get more information or help with other payment options.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

Your payment is due on the first of the month after you receive your bill in the mail. You can make your payment by check and mail it to us at Healthfirst Health Plan, Inc., P.O. Box 48243, Newark, NJ 07101-4843. Please make your check payable to “Healthfirst Health Plan, Inc.” and write your account number on the check (your account number will be printed on your bill). Do not make your check payable to “Medicare”, “CMS”, or “HHS.”

Option 2: You can pay online using your checking/savings account, or your credit or debit card

You can also pay your bill online using your checking or savings account, your credit card, or your debit card, by visiting www.healthfirstbillpay.org and making a one-time payment, or start automatic repeating payments (your payment will be automatically withdrawn from your bank account or credit/debit card each billing cycle). If you select the automatic payment option, your premium amount will be withdrawn from your account about the same time of the month that you set up your first automatic payment. For more information or for help with paying your bill online, please contact Member Services at the number on the back of this booklet.

Option 3: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Services for more information on how to pay your monthly plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Services are printed on the back of this booklet.)

What to do if you are having trouble paying your plan premium
Your plan premium is due in our office by the first day of the month after you receive your bill.

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back of this booklet.)

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the “Extra Help” program or if you lose your eligibility for the “Extra Help” program during the year. If a member qualifies for “Extra Help” with their prescription drug costs, the “Extra Help” program will pay part of the member’s monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the “Extra Help” program in Chapter 2, Section 7.

SECTION 5 Medicaid Monthly Spend-down (Surplus Income) for Healthfirst CompleteCare

Section 5.1 Monthly spend-down payment

A spend-down amount or surplus amount is the amount of net available income determined by the New York City Human Resources Administration or Local District of Social Services that a member must pay monthly to Healthfirst CompleteCare in accordance with the requirements of the medical assistance program. Healthfirst CompleteCare members with a surplus will receive a monthly invoice on or about the 15th of each month.

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

Monthly spend-down payments should be mailed to:

Healthfirst Health Plan, Inc.
P.O. Box 95000
Philadelphia, PA 19195-5170

SECTION 6  Please keep your plan membership record up to date

| Section 6.1 | How to help make sure that we have accurate information about you |

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group/IPA.

The doctors, hospitals, pharmacists, and other providers in the plan’s network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost-sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back of this booklet).

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.
Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That’s because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 8 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don’t need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back of this booklet).

SECTION 7 We protect the privacy of your personal health information

Section 7.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 8 How other insurance works with our plan

Section 8.1 Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the number of people
employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

- If you’re under 65 and disabled and you or your family member is still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.

- If you’re over 65 and you or your spouse is still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers’ compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare and/or employer group health plans have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.
CHAPTER 2

Important phone numbers and resources
**Chapter 2. Important phone numbers and resources**

<table>
<thead>
<tr>
<th>SECTION</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
</table>
| SECTION 1 | Healthfirst CompleteCare contacts  
(how to contact us, including how to reach Member Services  
at the plan) | 20   |
| SECTION 2 | Medicare  
(how to get help and information directly  
from the Federal Medicare program) | 29   |
| SECTION 3 | State Health Insurance Assistance Program  
(free help,  
information, and answers to your questions about Medicare) | 31   |
| SECTION 4 | Quality Improvement Organization  
(paid by Medicare  
to check on the quality of care for people with Medicare) | 32   |
| SECTION 5 | Social Security | 33   |
| SECTION 6 | Medicaid  
(a joint Federal and state program that helps with  
medical costs for some people with limited income and  
resources) | 34   |
| SECTION 7 | Information about programs to help people pay for their  
prescription drugs | 36   |
| SECTION 8 | How to contact the Railroad Retirement Board | 40   |
SECTION 1 Healthfirst CompleteCare contacts
(how to contact us, including how to reach Member Services at the plan)

How to contact our plan’s Member Services

For assistance with claims, billing or member card questions, please call or write to Healthfirst CompleteCare Member Services. We will be happy to help you.

<table>
<thead>
<tr>
<th>Method</th>
<th>Member Services – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-260-1010</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week from 8am to 8pm.</td>
</tr>
<tr>
<td></td>
<td>Member Services also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-888-542-3821</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week from 8am to 8pm.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Healthfirst Medicare Plan</td>
</tr>
<tr>
<td></td>
<td>Member Services</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 5165</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10274-5165</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:webmaster@healthfirst.org">webmaster@healthfirst.org</a></td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You may call us if you have questions about our coverage decision process.

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage Decisions for Medical Care – Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALL</strong></td>
<td>1-888-394-4327</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Monday through Friday from 8:30am to 5:30pm.</td>
</tr>
<tr>
<td><strong>TTY</strong></td>
<td>1-888-542-3821</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week from 8am to 8pm.</td>
</tr>
<tr>
<td><strong>WRITE</strong></td>
<td>Healthfirst Medicare Plan Utilization Management Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 5166</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10274-5166</td>
</tr>
<tr>
<td><strong>WEBSITE</strong></td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Appeals for Medical Care - Contact Information</th>
</tr>
</thead>
</table>
| CALL   | For standard appeals: 1-888-260-1010  
7 days a week from 8am to 8pm.  
For expedited (fast) appeals: 1-877-779-2959  
Monday through Friday from 8:30am to 5:30pm.  
Calls to these numbers are free. |
| TTY    | 1-888-542-3821  
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
Calls to this number are free. 7 days a week from 8am to 8pm. |
| WRITE  | Healthfirst Medicare Plan  
Appeals and Grievances Unit  
P.O. Box 5166  
New York, NY 10274-5166 |
| WEBSITE| www.healthfirst.org/medicare |
How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Complaints about Medical Care</th>
<th>- Contact Information</th>
</tr>
</thead>
</table>
| CALL         |                             | For standard complaints: 1-888-260-1010  
7 days a week from 8am to 8pm.  

For expedited (fast) complaints: 1-877-779-2959  
Monday through Friday from 8:30am – 5:30pm.  

Calls to these numbers are free. |
| TTY          | 1-888-542-3821               | This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  

Calls to this number are free. 7 days a week from 8am to 8pm |
| WRITE        | Healthfirst Medicare Plan  
Appeals and Grievances Unit  
P.O. Box 5166  
New York, NY 10274-5166   |
| MEDICARE WEBSITE | You can submit a complaint about Healthfirst CompleteCare directly to Medicare. To submit an online complaint to Medicare go to  
How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Coverage Decisions for Part D Prescription Drugs - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-260-1010</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
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<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>1-855-633-7673</td>
</tr>
<tr>
<td>WRITE</td>
<td>CVS Caremark Part D Services</td>
</tr>
<tr>
<td></td>
<td>MC 109</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52000</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85072-2000</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints).

<table>
<thead>
<tr>
<th>Method</th>
<th>Appeals for Part D Prescription Drugs - Contact Information</th>
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<tr>
<td>CALL</td>
<td>1-888-260-1010</td>
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<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
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<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>1-855-633-7673</td>
</tr>
<tr>
<td>WRITE</td>
<td>CVS Caremark Part D Services</td>
</tr>
<tr>
<td></td>
<td>MC109</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 52000</td>
</tr>
<tr>
<td></td>
<td>Phoenix, AZ 85072-2000</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan’s coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<table>
<thead>
<tr>
<th>Method</th>
<th>Complaints about Part D prescription drugs - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-260-1010</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>FAX</td>
<td>1-866-217-3353</td>
</tr>
<tr>
<td>WRITE</td>
<td>CVS Caremark Medicare Part D Grievance Department</td>
</tr>
<tr>
<td></td>
<td>PO Box 30016</td>
</tr>
<tr>
<td></td>
<td>Pittsburgh, PA 15222-0330</td>
</tr>
<tr>
<td>MEDICARE</td>
<td>You can submit a complaint about Healthfirst CompleteCare directly to Medicare. To submit an online complaint to Medicare go to <a href="https://www.medicare.gov/MedicareComplaintForm/home.aspx">https://www.medicare.gov/MedicareComplaintForm/home.aspx</a>.</td>
</tr>
</tbody>
</table>
Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

<table>
<thead>
<tr>
<th>Method</th>
<th>Payment Requests – Part C Medical Bills - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-260-1010</td>
</tr>
<tr>
<td></td>
<td>7 days a week from 8am to 8pm.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-888-542-3821</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 7 days a week from 8am to 8pm.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Healthfirst Medicare Plan</td>
</tr>
<tr>
<td></td>
<td>Claims Department</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 5165</td>
</tr>
<tr>
<td></td>
<td>New York, NY 10274-5165</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
## Payment Requests – Part D Prescription Drug Bills

<table>
<thead>
<tr>
<th>Method</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-888-260-1010&lt;br&gt; Calls to this number are free.&lt;br&gt; 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>711&lt;br&gt; This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.&lt;br&gt; Calls to this number are free.&lt;br&gt; 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>WRITE</td>
<td>CVS Caremark&lt;br&gt; Paper Claims Department – RxClaim&lt;br&gt; P.O. Box 52066&lt;br&gt; Phoenix, AZ 85072-2066</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
</tr>
</tbody>
</table>
SECTION 2  Medicare  
(how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-MEDICARE, or 1-800-633-4227</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>24 hours a day, 7 days a week.</td>
</tr>
</tbody>
</table>

| TTY      | 1-877-486-2048  |
|          | This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
|          | Calls to this number are free. |

<p>| WEBSITE  | <a href="https://www.medicare.gov">https://www.medicare.gov</a>  |
|          | This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. |
|          | The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: |
|          |  • Medicare Eligibility Tool: Provides Medicare eligibility status information. |
|          |  • Medicare Plan Finder: Provides personalized information |</p>
<table>
<thead>
<tr>
<th><strong>Method</strong></th>
<th><strong>Medicare - Contact Information</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <em>estimate</em> of what your out-of-pocket costs might be in different Medicare plans.</td>
</tr>
<tr>
<td></td>
<td>You can also use the website to tell Medicare about any complaints you have about Healthfirst CompleteCare:</td>
</tr>
<tr>
<td></td>
<td>• <strong>Tell Medicare about your complaint:</strong> You can submit a complaint about Healthfirst CompleteCare directly to Medicare. To submit a complaint to Medicare, go to: <a href="https://www.medicare.gov/MedicareComplaintForm/home.aspx">https://www.medicare.gov/MedicareComplaintForm/home.aspx</a></td>
</tr>
<tr>
<td></td>
<td>Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</td>
</tr>
<tr>
<td></td>
<td>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</td>
</tr>
</tbody>
</table>
SECTION 3  State Health Insurance Assistance Program  
(free help, information, and answers to your  
questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In New York, the SHIP is called The Health Insurance Information Counseling and Assistance Program, or HIICAP.

HIICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HIICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HIICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<table>
<thead>
<tr>
<th>Method</th>
<th>The Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York SHIP) - Contact Information</th>
</tr>
</thead>
</table>
| CALL   | 1-800-701-0501  
Calls to this number are free.  
Monday through Friday 8am to 5pm |
| WRITE  | New York City:  
New York City Department for the Aging  
2 Lafayette Street  
New York, NY 10007  

Nassau County:  
Nassau County Department of Senior Citizen Affairs  
60 Charles Lindbergh Boulevard, Suite #260  
Uniondale, NY 11553-3691  
seniors@hhsnassaucountyny.us  

Westchester County:  
Department of Senior Programs & Services  
9 South First Avenue, 10th Floor  
Mt. Vernon, NY 10550-3414  
jsw1@westchestergov.com |
| WEBSITE | www.aging.ny.gov/healthbenefits |
SECTION 4 Quality Improvement Organization
(paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For New York, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

<table>
<thead>
<tr>
<th>Method</th>
<th>Livanta (New York’s Quality Improvement Organization) - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-866-815-5440&lt;br&gt;Monday-Friday 8am-5pm, Saturday, Sunday and holidays 11am-3pm&lt;br&gt;Calls to this number are free.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-866-868-2289&lt;br&gt;This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.&lt;br&gt;Calls to this number are not free.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Livanta&lt;br&gt;B FCC-QIO Program&lt;br&gt;9090 Junction Drive, Suite 10&lt;br&gt; Annapolis Junction, MD 20701&lt;br&gt;Appeals Fax: 1-855-236-2423&lt;br&gt;All other reviews Fax: 1-844-420-6671</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.livanta.com">www.livanta.com</a></td>
</tr>
</tbody>
</table>
SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

<table>
<thead>
<tr>
<th>Method</th>
<th>Social Security - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-772-1213</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 7:00 am to 7:00 pm, Monday through Friday.</td>
</tr>
<tr>
<td></td>
<td>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-325-0778</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 7:00 am to 7:00 pm, Monday through Friday.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="https://www.ssa.gov">https://www.ssa.gov</a></td>
</tr>
</tbody>
</table>
SECTION 6  Medicaid  
(a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Healthfirst CompleteCare is a Medicaid Advantage Plus (MAP) Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) that coordinates care and services available to you through both the Medicare and Medicaid programs. In order to join Healthfirst CompleteCare, you must be eligible for both Medicare and Full Medicaid Benefits (dual eligible).

In addition you must:
1) Be 18 years of age or older
2) Reside in the plan’s service area (Bronx, Kings, Nassau, New York, Queens, Richmond and Westchester Counties)
3) Have a chronic illness or disability that makes you eligible for a nursing home level of care
4) Need one or more of the following services for more than 120 days from the date that you join our 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, or
   - Consumer Directed Personal Care Services

Please refer to the Healthfirst CompleteCare (HMO SNP) Member Handbook for more information about the Medicaid-covered benefits you receive as a dual eligible member of Healthfirst CompleteCare.

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for Full Medicaid Benefits (QMB+).)
• **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for Full Medicaid Benefits (SLMB+).)

• **Qualifying Individual (QI):** Helps pay Part B premiums.

• **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

If you have questions about the assistance you get from Medicaid, contact the New York State Department of Health Medicaid Program.

For additional assistance, the State Office for the Aging (SOFA) employs an ombudsman in each county of New York State. An Ombudsman is an advocate for residents of nursing homes, board and care homes, and assisted living. Ombudsmen provide information about how to find a facility and what to do to get quality care. They are trained to resolve problems. If you want, the ombudsman can also assist you with complaints. Please contact the Independent Consumer Advocacy Network (ICAN) at 1-844-614-8800 (TTY users call 711, then follow the prompts to dial 844-614-8800, Monday-Friday, 8:00 am – 6:00 pm. The call and the help are free. You can also go online at www.icannys.org.

<table>
<thead>
<tr>
<th>Method</th>
<th>New York State Department of Health Medicaid Program - Contact Information</th>
</tr>
</thead>
</table>
| CALL     | New York Medicaid CHOICE Helpline: 1-800-505-5678  
TTY: 1-888-329-1541  
Monday to Friday, 8:30 am – 8:30 pm; Saturday, 10 am – 6pm  
New York State Department of Health (Complaints):  
1-866-712-7197  
Calls to these numbers are free. |
| WRITE    | New York State Department of Health  
Corning Tower, Empire State Plaza  
Albany, NY 12237 |
| WEBSITE  | www.health.ny.gov/health_care/medicaid/index.htm |
The State Office for the Aging (SOFA) helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan.

<table>
<thead>
<tr>
<th>Method</th>
<th>State Office for the Aging (SOFA) - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-342-9871</td>
</tr>
<tr>
<td>WRITE</td>
<td>New York State Office for the Aging</td>
</tr>
<tr>
<td></td>
<td>2 Empire State Plaza</td>
</tr>
<tr>
<td></td>
<td>Albany, New York 12223-1251</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.aging.ny.gov">www.aging.ny.gov</a></td>
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The New York State Office of Long Term Care Ombudsman program helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<table>
<thead>
<tr>
<th>Method</th>
<th>New York State Office of Long Term Care Ombudsman - Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-855-582-6769</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.ltcombudsman.ny.gov">www.ltcombudsman.ny.gov</a></td>
</tr>
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</table>

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this “Extra Help”.

If you have questions about “Extra Help”, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information).
If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- You should call Member Services at the phone number located on the back cover of this booklet and provide us with the best available evidence to support your correct copayment level. Some examples of this include (but are not limited to) proof of Medicaid coverage or an award letter from the Social Security Administration. Your documentation can be sent to us via fax at 1-212-801-3250 or by mail to the following address:
  Healthfirst Member Services
  P.O. Box 5165
  New York, NY 10274-5165

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.
What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance at HIV Uninsured Care Programs, ADAP. Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call HIV Uninsured Care Programs, ADAP at 1-800-542-2437, TTY 1-518-459-0121, Monday to Friday from 8 am to 5 pm.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call HIV Uninsured Care Programs, ADAP at 1-800-542-2437.

What if you get “Extra Help” from Medicare to help pay your prescription drug costs? Can you get the discounts?

Most of our members get “Extra Help” from Medicare to pay for their prescription drug plan costs. If you get “Extra Help” the Medicare Coverage Gap Discount Program does not apply to you. If you get “Extra Help”, you already have coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next Part D Explanation of Benefits (Part D EOB) notice. If the discount doesn’t appear on your Part D Explanation of Benefits, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In New York, the State Pharmaceutical Assistance Program is the Elderly Pharmaceutical Insurance Coverage (EPIC).

<table>
<thead>
<tr>
<th>Method</th>
<th>Elderly Pharmaceutical Insurance Coverage (EPIC) (New York’s State Pharmaceutical Assistance Program) - Contact Information</th>
</tr>
</thead>
</table>
| CALL   | 1-800-332-3742  
Monday-Friday, 8:30am-5pm  
Calls to this number are free. |
| TTY    | 1-800-290-9138  
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
Calls to this number are free. |
| WRITE  | EPIC  
P.O. Box 15018  
Albany, NY 12212-5018  
Email: epic@health.state.ny.us |
| WEBSITE| www.health.ny.gov/health_care/epic |
SECTION 8  How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

<table>
<thead>
<tr>
<th>Method</th>
<th>Railroad Retirement Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-877-772-5772</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free.</td>
</tr>
<tr>
<td></td>
<td>Available 9:00 am to 3:30 pm, Monday, Tuesday, Thursday and Friday; 9am - 12pm Wednesday only.</td>
</tr>
<tr>
<td></td>
<td>Closed on Federal Holidays</td>
</tr>
<tr>
<td></td>
<td>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-312-751-4701</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are not free.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="https://rrb.gov/">https://rrb.gov/</a></td>
</tr>
</tbody>
</table>
CHAPTER 3

Using the plan’s coverage for your medical and other covered services
### Chapter 3. Using the plan’s coverage for your medical and other covered services

<table>
<thead>
<tr>
<th>SECTION 1</th>
<th>Things to know about getting your medical care and other services covered as a member of our plan</th>
<th>44</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1.1</td>
<td>What are “network providers” and “covered services”?</td>
<td>44</td>
</tr>
<tr>
<td>Section 1.2</td>
<td>Basic rules for getting your medical care and other services covered by the plan</td>
<td>44</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 2</th>
<th>Use providers in the plan’s network to get your medical care and other services</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2.1</td>
<td>You must choose a Primary Care Provider (PCP) to provide and oversee your care</td>
<td>45</td>
</tr>
<tr>
<td>Section 2.2</td>
<td>What kinds of medical care and other services can you get without getting approval in advance from your PCP?</td>
<td>47</td>
</tr>
<tr>
<td>Section 2.3</td>
<td>How to get care from specialists and other network providers</td>
<td>47</td>
</tr>
<tr>
<td>Section 2.4</td>
<td>How to get care from out-of-network providers</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 3</th>
<th>How to get covered services when you have an emergency or urgent need for care or during a disaster</th>
<th>49</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3.1</td>
<td>Getting care if you have a medical emergency</td>
<td>49</td>
</tr>
<tr>
<td>Section 3.2</td>
<td>Getting care when you have an urgent need for services</td>
<td>50</td>
</tr>
<tr>
<td>Section 3.3</td>
<td>Getting care during a disaster</td>
<td>51</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 4</th>
<th>What if you are billed directly for the full cost of your covered services?</th>
<th>51</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 4.1</td>
<td>You can ask us to pay our share of the cost for covered services</td>
<td>51</td>
</tr>
<tr>
<td>Section 4.2</td>
<td>What should you do if services are not covered by our plan?</td>
<td>52</td>
</tr>
</tbody>
</table>
SECTION 5 How are your medical services covered when you are in a “clinical research study”? .......................................................... 52

Section 5.1 What is a “clinical research study”? .................................................. 52

Section 5.2 When you participate in a clinical research study, who pays for what? ....................................................................................... 53

SECTION 6 Rules for getting care covered in a “religious non-medical health care institution” ................................................................. 54

Section 6.1 What is a religious non-medical health care institution? .............. 54

Section 6.2 What care from a religious non-medical health care institution is covered by our plan? ................................................................. 55

SECTION 7 Rules for ownership of durable medical equipment .................. 55

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan? .......................... 55
SECTION 1 Things to know about getting your medical care and other services covered as a member of our plan

This chapter explains what you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care and other services that are covered by the plan.

For the details on what medical care and other services are covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (Benefits Chart, what is covered).

Section 1.1 What are “network providers” and “covered services”? 

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- “Providers” are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.

- “Network providers” are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.

- “Covered services” include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care and other services covered by the plan

As a Medicare and Medicaid health plan, Healthfirst CompleteCare must cover all services covered by Original Medicare and other services.
Healthfirst CompleteCare will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Benefits Chart** (this chart is in Chapter 4 of this booklet).

- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan’s network) will not be covered. **Here are three exceptions:**
  
  o The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.

  o If you need medical care that Medicare or Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Prior authorization from our plan is required in advance of obtaining out-of-network services. In this situation, we will cover these services as if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

  o The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area.

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**SECTION 2**  
Use providers in the plan’s network to get your medical care and other services

**Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care**

---

**What is a “PCP” and what does the PCP do for you?**

When you become a member of our plan, you must choose a network provider to be your Primary Care Provider, or PCP. The name and office telephone number of your PCP is printed on your Member ID card. Your PCP is a physician, nurse practitioner, or other health care professional who meets state requirements and is trained to give you
basic medical care. As we explain below, you will get most of your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. This includes, but is not limited to:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care

“Coordinating” your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP. In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office. The enclosed Privacy Notice tells you how we will protect the privacy of your medical records and personal health information.

**How do you choose your PCP?**

You can choose your PCP either by using the Healthfirst CompleteCare Provider/Pharmacy Directory or contacting Member Services at 1-888-260-1010 (TTY users should call 1-888-542-3821), 7 days a week from 8am to 8pm. A Member Services representative will be happy to assist you with selecting a new PCP and can also answer any other questions you may have.

**Changing your PCP**

You may change your PCP for any reason, at any time. Also, it’s possible that your PCP might leave our plan’s network of providers and you would have to find a new PCP. If you do change your PCP, please remember that you may be limited to specific specialists or hospitals to which that PCP refers. This is also noted in Section 2.3 below.

To change your PCP, call Member Services (contact information is above and on the back of this booklet). Member Services will check to be sure the PCP you want to switch to is accepting new patients. They will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will begin. They will also send you a new membership card that shows the name and phone number of your new PCP. Unless Member Services states otherwise, your PCP change will be effective the day that you call Member Services.

If you are undergoing a specified course of treatment with a provider who leaves our network, we will authorize a transitional period of up to 90 days from the date the provider leaves Healthfirst to ensure continuity of your care and prevent any disruptions
in your treatment plan. In addition, if you are in your second or third trimester of pregnancy (more than three (3) months pregnant) when your provider leaves our network, we will authorize a transitional period of up to 60-days postpartum (after the baby is born) to ensure continuity of care. You must call Member Services to arrange transitional care.

| Section 2.2 | What kinds of medical care and other services can you get without getting approval in advance from your PCP? |

You can get the services listed below without getting approval in advance from your PCP.

- Routine women’s health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan’s service area.

Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back of this booklet.)

| Section 2.3 | How to get care from specialists and other network providers |

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists care for patients with certain bone, joint, or muscle conditions.

You do not need approval in advance (a “referral”) from your PCP in order to see a network specialist. You may “self-refer” and seek these services on your own. However, if your specialist thinks that you need specialized treatment, your specialist may need to get approval in advance from our plan (this is called getting “prior authorization”).
For certain services (for example, home health services or durable medical equipment), your PCP or specialist will need to get “prior authorization” (approval in advance) from us before providing those services.

Please refer to the Benefits Chart in Chapter 4 for a complete listing of all services that require prior authorization.

**What if a specialist or another network provider leaves our plan?**

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days’ notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

You can reach Healthfirst CompleteCare Member Services by calling 1-888-260-1010 (TTY users should call 1-888-542-3821) 7 days a week from 8am to 8pm.

### Section 2.4 How to get care from out-of-network providers

Generally, you must obtain your treatment from network providers. However, some exceptions apply, such as if you require emergency services or urgently needed services when the network is not available (generally, when you are out of the service area), and out-of-area dialysis services. In these circumstances, prior authorization to seek out-of-network treatment is not required.
However, in the event you require specialized services that are not available within our network, contact the plan to obtain prior authorization for out-of-network services. If the plan authorizes out-of-network services, your cost sharing for the out-of-network services will be the same as if you had received your care from a network provider.

SECTION 3 How to get covered services when you have an emergency or urgent need for care or during a disaster

Section 3.1 Getting care if you have a medical emergency

What is a “medical emergency” and what should you do if you have one?

A “medical emergency” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

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

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You may do this by calling Member Services at 1-888-260-1010 (TTY users should call 1-888-542-3821) 7 days a week from 8am to 8pm. This information is also listed on the back of your Healthfirst CompleteCare medical identification card and on the back of this Evidence of Coverage booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

You are also covered for emergency care and urgent care worldwide. Please see Chapter 4 for more information.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors 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 are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn’t a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn’t a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- or – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services

What are “urgently needed services”?

“Urgently needed services” are non-emergency, unforeseen medical illnesses, injuries, or conditions that require immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan’s service area when you have an urgent need for care?

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

To access urgently needed services, simply contact your PCP or go to the nearest urgent care center.
What if you are outside the plan’s service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Suppose that you are temporarily outside our plan’s service area. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan’s network. In this situation (when you are outside the service area and cannot get services from a network provider), our plan will cover urgently needed services that you get from any provider worldwide.

Section 3.3 Getting care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: www.healthfirst.org/medicare for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid for your covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs) for information about what to do.
Section 4.2 What should you do if services are not covered by our plan?

Healthfirst CompleteCare covers all medical services that are medically necessary, are listed in the plan’s Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren’t covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. For all Medicare-covered services, your out-of-pocket costs for these benefits after you have reached the benefit limit will not count toward your annual maximum out-of-pocket limit of $3,400. You can call Member Services when you want to know how much of your benefit limit you have already used.

In most cases, your additional Medicaid benefits and services provide you with continued coverage you need once you reach the Medicare-defined benefit limitations. Therefore, before you pay for the cost of benefits or services, call Member Services to check if the service is covered by Medicaid.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.
Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has \textit{not} approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study \textit{and} you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do \textit{not} need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do \textit{not} need to be part of our plan’s network of providers.

Although you do not need to get our plan’s permission to be in a clinical research study, you do \textit{need} to tell us before you start participating in a clinical research study.

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

\textbf{Section 5.2 When you participate in a clinical research study, who pays for what?}

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren’t in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.
In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

**Do you want to know more?**

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (https://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

**SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”**

**Section 6.1 What is a religious non-medical health care institution?**

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member’s religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.
Section 6.2  What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan’s coverage of services you receive is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Your costs for approved stays will be the same as those for Inpatient Hospital care (see the benefits chart in Chapter 4 for more information).

SECTION 7  Rules for ownership of durable medical equipment

Section 7.1  Will you own the durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Healthfirst CompleteCare, however, you usually will not acquire ownership of rented DME items no
matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the DME item to you. Call Member Services (phone numbers are printed on the back of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

**What happens to payments you made for durable medical equipment if you switch to Original Medicare?**

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.
CHAPTER 4

Benefits Chart (what is covered)
Chapter 4. Benefits Chart (What is covered)

SECTION 1  Understanding your out-of-pocket costs for covered services................................................................. 59

Section 1.1  You pay nothing for your covered services .................................................. 59

Section 1.2  What is the most you will pay for Medicare Part A and Part B covered medical services? .......................................................... 59

SECTION 2  Use the Benefits Chart to find out what is covered for you and how much you will pay......................................................... 60

Section 2.1  Your medical benefits, including long-term care or home and community-based services, and costs as a member of the plan... 60

Section 2.2  Additional Medicaid-covered benefits for Healthfirst CompleteCare members .......................................................... 104

SECTION 3  What services are covered outside of Healthfirst CompleteCare ................................................................. 113

Section 3.1  Services not covered by Healthfirst CompleteCare......................... 113

SECTION 4  What services are not covered by the plan or Medicaid ...... 114

Section 4.1  Services not covered by the plan (exclusions) or Medicaid........ 114
SECTION 1  Understanding your out-of-pocket costs for covered services

This chapter focuses on what services are covered and what you pay for these services. It includes a Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Healthfirst CompleteCare. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1  You pay nothing for your covered services

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans’ rules for getting your care. (See Chapter 3 for more information about the plans’ rules for getting your care.)

Section 1.2  What is the most you will pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum. You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Healthfirst CompleteCare, the most you will have to pay out-of-pocket for Part A and Part B services in 2019 is $3,400. The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are indicated in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
SECTION 2 Use the **Benefits Chart** to find out what is covered for you

| Section 2.1 | Your medical benefits, including long-term care or home and community-based services, and costs as a member of the plan |

The Benefits Chart on the following pages lists the services Healthfirst CompleteCare covered. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, and equipment) **must** be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care.
- Some of the services listed in the Benefits Chart are covered **only** if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Benefits Chart. You can find the requirement in the right column.

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost-sharing for Medicare services. Medicaid also covers services Medicare does not cover, like long-term care, over-the-counter drugs, and home and community-based services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2019* Handbook. View it online at https://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2019, either Medicare or our plan will cover those services.
If you are within our plan’s 3-month period of deemed continued eligibility, we will continue to provide all appropriate Medicare Advantage plan covered benefits. However, during this period, the plan is not liable for more than plan premium and cost-sharing amounts owed by members who have not lost their special needs status. Medicare cost sharing amounts for Medicare basic and supplemental benefits do not change during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.
You will see this apple next to the preventive services in the benefits chart.

**Benefits Chart**

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong>&lt;br&gt;A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</td>
<td>$0 copay&lt;br&gt;There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</td>
</tr>
<tr>
<td><strong>Acupuncture</strong>&lt;br&gt;You are covered for up to thirty (30) visits annually when services are received from certified Healthfirst network providers.</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Ambulance services</strong>&lt;br&gt;Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person’s health or if authorized by the plan.&lt;br&gt;Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation could endanger the person’s health and that transportation by ambulance is medically required.</td>
<td>$0 copay&lt;br&gt;Prior authorization from the Healthfirst Utilization Management department is required for air ambulance services and non-emergency ambulance services.</td>
</tr>
</tbody>
</table>

Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual wellness visit</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. <strong>Note:</strong> Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Bone mass measurement</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</td>
<td></td>
</tr>
<tr>
<td><strong>Breast cancer screening (mammograms)</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</td>
</tr>
<tr>
<td>• One baseline mammogram between the ages of 35 and 39</td>
<td></td>
</tr>
<tr>
<td>• One screening mammogram every 12 months for women age 40 and older</td>
<td></td>
</tr>
<tr>
<td>• Clinical breast exams once every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac rehabilitation services</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</td>
<td>Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| **Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)**  
We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you’re eating well. | $0 copay  
There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. |
| **Cardiovascular disease testing**  
Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). | $0 copay  
There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. |
| **Cervical and vaginal cancer screening**  
Covered services include:  
- For all women: Pap tests and pelvic exams are covered once every year. | $0 copay  
There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. |
| **Chiropractic services**  
Covered services include:  
- We cover only manual manipulation of the spine to correct subluxation. | $0 copay for each visit.  
Prior authorization from American Specialty Health is required. |
## Services that are covered for you

### Colorectal cancer screening

For people 50 and older, the following are covered:
- Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months

One of the following every 12 months:
- Guaiac-based fecal occult blood test (gFOBT)
- Fecal immunochemical test (FIT)

DNA based colorectal screening every 3 years

For people at high risk of colorectal cancer, we cover:
- Screening colonoscopy (or screening barium enema as an alternative) every 24 months

For people not at high risk of colorectal cancer, we cover:
- Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 copay</td>
</tr>
</tbody>
</table>

There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

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### Dental services

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Healthfirst CompleteCare members receive these additional dental benefits not covered by Original Medicare.

Additional benefits include diagnostic and preventive services, restorative services, oral surgery, root canal surgery, periodontics (prosthetics/crowns), and denture adjustments and repairs. Certain individual services may require prior authorization from DentaQuest, the Healthfirst Medicare Plan contracted dental provider.

<table>
<thead>
<tr>
<th>What you must pay for Medicare covered dental benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 copay for up to one (1) oral exam every six (6) months.</td>
</tr>
<tr>
<td>$0 copay for up to one (1) cleaning every six (6) months.</td>
</tr>
<tr>
<td>$0 copay for up to one (1) dental X-ray visit every six (6) months.</td>
</tr>
</tbody>
</table>
### Services that are covered for you

#### Dental services (continued)

**Benefit limitations and exclusions:**

- Oral exams, bitewing x-rays, prophylaxes (cleanings), scaling, and fluoride may not be provided more often than once every 6 months.
- Periodontic scaling and root planning is only covered once every 24 months (only two quadrants will be reimbursed on the same date of service).
- Full mouth and panoramic x-rays may not be provided more often than once every 36 months.
- Fillings are limited to once every 12 months for the same tooth/tooth surface.
- Endodontics and extractions are limited to one surgery per tooth per lifetime.
- Crowns, bridges, and periodontal work may not be provided more often than once per tooth every five (5) years.
  - Dentures are limited to one set every five (5) years.
    - Replacement of lost, stolen, or broken dentures less than five (5) years of age does not meet criteria for pre-authorization of a new denture.
    - Bridges (excluding third molars) are covered to replace one (1) upper front tooth or two (2) adjacent lower front teeth and there cannot be any missing back teeth.
- Certain procedures may have age limitations. A list of such services is available upon request.
- Services not furnished by a dentist, unless the service is performed by a licensed dental hygienist under the supervision of a dentist or for an X-ray ordered by a dentist.
- General anesthesia, analgesia and any service provided in a hospital environment.
- Any dental procedures, which are undertaken primarily for cosmetic reasons or to treat congenital or developmental malformations.

### What you must pay when you get these services

You must access all dental treatment from providers through the Healthfirst Medicare Plan contracted dental network.

All covered dental services must be medically necessary.

Individual dental procedures may require prior authorization from DentaQuest, the Healthfirst contracted dental network provider.
Services that are covered for you

Dental services (continued)

- Restorations, crowns, or fixed prosthetics when acceptable results can be achieved with alternative methods or materials. In cases where the selection of a more expensive treatment plan is decided upon, Healthfirst CompleteCare will allow for the least costly alternative and the patient is responsible for all additional fees charged by the dentist.
- All procedures subject to review will be evaluated for long-term prognosis, as well as necessity for treatment. Included in this evaluation, but not limited to, are bone support, furcation involvement, periodontal condition, and sub-crestal decay.
- Partial dentures with resin base (including any conventional clasps, rests and teeth)
- Retrograde fillings, immediate dentures, flexible dentures, crown lengthening, onlays, and core build up are not covered services.
- Implants are not a covered service.
- Occlusal guards/Night guards are not covered
- While general anesthesia is not a covered benefit for members, local anesthesia is considered part of the reimbursement for services such as, but not limited to, fillings, extractions, and root canal therapy.
- Pontic crowns are only covered for certain teeth as defined by the provider’s office reference manual. The pontic crowns are covered in ORM for teeth 6-11 and teeth 22-27
- Porcelain crowns are only covered for certain teeth as defined by the provider’s office reference manual. The porcelain crowns covered in ORM for teeth 5-12 and teeth 22-27
- Certain Diagnostic Radiology services are not covered under the dental benefit. Please contact Member Services for a full list of covered services.
Services that are covered for you

Dental services (continued)

- Additional Exclusions: Periodontal maintenance procedures, Repairing of resin denture base, repairing of cast framework, repairing or replacing broken clasp, adding clasp to existing partial denture, replacing all teeth and acrylic on cast metal framework (maxillary), replacing all teeth and acrylic on cast metal framework (mandibular)
- Root amputation not covered

Benefit Limits for Dentures:
1. If there is a pre-existing prosthesis, it must be at least 5 years old and unserviceable to qualify for replacement.
2. Adjustments, repairs and relines are included with the denture fee within the first 6 months after insertion. After that time has elapsed:
   a. Adjustments are compensable at one per calendar year per recipient.
   b. Repairs are compensated at 2 repairs per denture per year, with 5 total denture repairs per 5 years.
   c. Relines are compensable once per denture every 36 months.
3. A new prosthesis is not compensable within 24 months of reline or repair of the existing prosthesis.
4. Replacement of lost or broken dentures less than 5 years of age is not a covered benefit.
5. Preformed dentures with teeth already mounted (that is, teeth set in acrylic before the initial impression) are not a covered benefit.
6. The fee for complete and partial dentures includes six months of post-insertion follow-up care including adjustments, repairs and relines.
7. All prosthetic appliances are inserted in the mouth and adjusted before a claim is submitted for payment.
8. When billing for partial and complete dentures, dentists must list the date that the final impressions were taken as the date of service. Recipients must be eligible on the date the final impressions are taken in order for the denture service to be covered.
### Services that are covered for you

<table>
<thead>
<tr>
<th>Services</th>
<th>When you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental services (continued)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>General anesthesia and IV sedation for Dental Procedures</strong></td>
<td></td>
</tr>
<tr>
<td><strong>criteria:</strong></td>
<td></td>
</tr>
<tr>
<td>• Five (5) or more simple and/or surgical extractions in more than one quadrant in one appointment</td>
<td></td>
</tr>
<tr>
<td>• Impacted wisdom teeth</td>
<td></td>
</tr>
<tr>
<td>• Surgical root recovery from maxillary antrum</td>
<td></td>
</tr>
<tr>
<td>• Surgical exposure of impacted or unerupted cuspids</td>
<td></td>
</tr>
<tr>
<td>• Radical excision of lesions in excess of 1.25 cm</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic</strong></td>
<td></td>
</tr>
<tr>
<td>Initial oral exam</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Periodic oral exam</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Radiographic</strong></td>
<td></td>
</tr>
<tr>
<td>Complete intraoral series, periapical, and bitewing films</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Intraoral periapical</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Each additional single film (periapical or bitewing)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Occlusal view X-ray</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Lateral jaw X-ray (each)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>One to four bitewing X-ray films</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Antero-posterior X-ray of head and jaw</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Panoramic (including bitewings) once every three (3) years</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Preventive</strong></td>
<td></td>
</tr>
<tr>
<td>Oral prophylaxis (cleaning) (adult &amp; child)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Emergency dental treatment (palliative treatment)</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Operative (Restorative) Services</strong></td>
<td></td>
</tr>
<tr>
<td>Permanent silver amalgam (1 surface)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Permanent silver amalgam (2 surfaces)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Permanent silver amalgam (3 surfaces)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Permanent silver amalgam (4 surfaces or more)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Composite filling (1 surface)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Composite filling (2 surfaces)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Composite filling (3 surfaces)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Composite filling (4 surfaces or more)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Pin retention (per tooth)</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>
### Services that are covered for you

### What you must pay when you get these services

### Dental services (continued)

**Periodontia**
- Scaling of teeth (full mouth)
- Gingivectomy (per quad)
- Occlusal adjustment
- Osseous surgery (per quad)

**Endodontics (including radiographs)**
- Single root canal filling
- Double root canal filling
- Triple or more root canal filling
- Apicoectomy (per root)

**Simple Extractions (including local anesthesia)**
- Single tooth
- Each additional tooth

**Oral Surgery Extractions (including local anesthesia)**
- Surgical extraction
- Extraction of tooth (soft tissue impaction)
- Extraction of tooth (partial bony impaction)
- Extraction of tooth (complete bony impaction)
- Alveolecctomy (per quad)

**Prosthetics – Dentures (includes adjustments/relines for 6 months following installation)**
- Full upper denture (including adjustments)
- Full lower denture (including adjustments)
- Partial upper denture (cast chrome base)
- Partial lower denture (cast chrome base)
- Repair broken full or partial denture
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental services (continued)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics – Crowns</strong></td>
<td></td>
</tr>
<tr>
<td>Acrylic with metal crown</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Porcelain crown</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Porcelain with metal crown</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Full cast crown</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Stainless steel crown</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Post</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Recementation (per crown)</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Prosthetics – Fixed Bridges</strong></td>
<td></td>
</tr>
<tr>
<td>Acrylic with metal bridge (crown or pontic)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Porcelain with bridge (crown or pontic)</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Full cast abutment</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Acrylic/metal abutment</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Porcelain metal abutment</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Recementation (bridges)</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Orthodontics</strong></td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Depression screening**

We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.

$0 copay

There is no coinsurance, copayment, or deductible for an annual depression screening visit.
### Diabetes screening

We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.

Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.

### Diabetes self-management training, diabetic services and supplies

For all people who have diabetes (insulin and non-insulin users). Covered services include:

- Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.
- For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.
- Diabetes self-management training is covered under certain conditions.
- Continuous glucose monitoring systems are not covered.
- For persons at risk of diabetes: Fasting plasma glucose tests. These tests are covered as long as they are medically necessary – please contact Member Services for more information.
**Services that are covered for you**

<table>
<thead>
<tr>
<th><strong>Durable medical equipment (DME) and related supplies</strong></th>
<th><strong>What you must pay when you get these services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Generally, Healthfirst CompleteCare covers any DME equipment covered by Original Medicare from the brands and manufacturers on this list. We will not cover other 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 DME that is not on our list, we will continue to cover this 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.) If you (or your provider) don’t agree with the plan’s coverage decision, you or your provider may file an appeal. You can also file an appeal if you don’t agree with your provider’s decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints).) Diabetic supplies are limited to Bayer/Ascensia, Healthfirst’s exclusive, preferred manufacturer.</td>
<td>$0 copay Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
</tbody>
</table>
Services that are covered for you

Durable medical equipment (DME) and related supplies (continued)

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

Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.

Emergency care

Emergency care refers to services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

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

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
<th>$0 copay for Emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 copay for Worldwide Emergency care</td>
<td>$0 for Worldwide Emergency</td>
</tr>
<tr>
<td>Transportation</td>
<td>Transportation</td>
</tr>
</tbody>
</table>

The maximum coverage limit amount for emergency and urgent care outside the U.S. is $100,000 per year.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency care (continued)</strong></td>
<td>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost sharing you would pay at a network hospital.</td>
</tr>
<tr>
<td>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Coverage is worldwide. Worldwide coverage is only for emergency, urgently needed services, or emergency transportation. To get emergency care or urgently needed services furnished in other countries reimbursed by Healthfirst, you'll need to give a Healthfirst Member Services Representative an itemized proof of payment and medical record of the care received. Healthfirst CompleteCare will not cover any Part D prescription drugs that you receive as part of your emergency or urgent care visit in another country.</td>
<td></td>
</tr>
<tr>
<td><strong>Fitness Benefit</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>SilverSneakers® by Tivity Health You have access to network fitness facilities and to all basic amenities plus group exercise classes. SilverSneakers FLEX® classes held at parks and community locations. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. You can go to <a href="http://www.SilverSneakers.com">www.SilverSneakers.com</a> to learn more about your fitness benefit, or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.</td>
<td></td>
</tr>
<tr>
<td><strong>Gender Dysphoria Services</strong></td>
<td>$0 copay for Gender Dysphoria Services.</td>
</tr>
<tr>
<td>Coverage of transition-related care and services for persons diagnosed with Gender Dysphoria. We cover services associated with Gender Dysphoria according to the New York State Department of Health (NYSDOH) criteria. For more information on Gender Dysphoria guidelines, please contact member services at the phone number printed on the back of this booklet or visit <a href="https://regs.health.ny.gov/volume-c-title-18/1262489358/section-5052-physicians-services">https://regs.health.ny.gov/volume-c-title-18/1262489358/section-5052-physicians-services</a>.</td>
<td>Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Health and wellness education programs</strong>&lt;br&gt;Contact Member Services for more information on Healthfirst CompleteCare’s health and wellness education programs.&lt;br&gt;This program includes sessions and materials focused on Health Education and Nutritional Education. This program will be provided by a certified health educator or other qualified health professional.</td>
<td><strong>$0 copay for six (6) sessions per year.</strong></td>
</tr>
<tr>
<td><strong>Healthfirst’s Nurse Help Line</strong>&lt;br&gt;Healthfirst’s Nurse Help Line is a toll-free phone service to which you can call 24 hours a day, 7 days a week for both answers to general health related questions and for assistance in accessing services.</td>
<td><strong>$0 copay</strong></td>
</tr>
<tr>
<td><strong>Hearing services</strong>&lt;br&gt;Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.&lt;br&gt;While Medicare-covered benefits do not include routine hearing exams or hearing aids, as a dual eligible member entitled to Full Medicaid Benefits, you are covered in full for one routine hearing exam every year and hearing aids as medically necessary.&lt;br&gt;Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.</td>
<td><strong>$0 copay for Medicare-covered diagnostic hearing exams.</strong>&lt;br&gt;<strong>$0 copay for up to one (1) routine hearing exam per year.</strong>&lt;br&gt;<strong>$0 copay per hearing aid as medically necessary.</strong></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>HIV screening</td>
<td>$0 copay</td>
</tr>
<tr>
<td>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</td>
<td>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</td>
</tr>
<tr>
<td>• One screening exam every 12 months</td>
<td></td>
</tr>
<tr>
<td>For women who are pregnant, we cover:</td>
<td></td>
</tr>
<tr>
<td>Up to three screening exams during a pregnancy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home health agency care</th>
<th>$0 copay for each home health visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to receiving home health services, a doctor must certify that you need home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</td>
<td>Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy</td>
<td></td>
</tr>
<tr>
<td>• Medical and social services</td>
<td></td>
</tr>
<tr>
<td>• Medical equipment and supplies</td>
<td></td>
</tr>
<tr>
<td>As a dual eligible member, you are entitled to Medicaid-covered additional services such as a physical therapist to supervise maintenance program for patients who have reached their maximum restorative potential or a nurse to pre-fill syringes for disabled individuals with diabetes and / or home health aide services as required by an approved plan of care developed by a certified home health agency.</td>
<td></td>
</tr>
</tbody>
</table>

Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.
### Services that are covered for you

#### Hospice care
You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you’re terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:
- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:
Original Medicare (rather than our plan) will pay for your hospice services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan’s network:
- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services
- If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Healthfirst CompleteCare.</td>
</tr>
<tr>
<td>$0 copay for a one-time Hospice consultation.</td>
</tr>
</tbody>
</table>

---

$0 copay for a one-time Hospice consultation.
## Hospice care (continued)

For services that are covered by Healthfirst CompleteCare but are not covered by Medicare Part A or B: Healthfirst CompleteCare will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services.

For drugs that may be covered by the plan’s Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 *(What if you’re in a Medicare-certified hospice)*.

**Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.

## Immunizations

Covered Medicare Part B services include:

- Pneumonia vaccine
- Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We also cover some vaccines under our Part D prescription drug benefit.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Healthfirst CompleteCare</strong> will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost sharing amount for these services.</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.3 <em>(What if you’re in a Medicare-certified hospice)</em>.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</td>
<td></td>
</tr>
<tr>
<td>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn’t elected the hospice benefit.</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>Covered Medicare Part B services include:</td>
<td>$0 copay</td>
</tr>
<tr>
<td>- Pneumonia vaccine</td>
<td></td>
</tr>
<tr>
<td>- Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</td>
<td></td>
</tr>
<tr>
<td>- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</td>
<td></td>
</tr>
<tr>
<td>- Other vaccines if you are at risk and they meet Medicare Part B coverage rules</td>
<td></td>
</tr>
<tr>
<td>We also cover some vaccines under our Part D prescription drug benefit.</td>
<td></td>
</tr>
</tbody>
</table>
## Inpatient hospital care

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor’s order. The day before you are discharged is your last inpatient day.

Covered services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate.

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 deductible.</td>
<td>$0 copay per day for unlimited inpatient days as medically necessary.</td>
</tr>
<tr>
<td>You will not be charged additional cost sharing for professional services.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization from the Healthfirst Utilization Management department is only required for elective admissions, not emergency admissions. However, the admitting physician/ facility is encouraged to contact Healthfirst as soon as possible following an emergent admission to ensure appropriate post-stabilization care and discharge planning.</td>
<td></td>
</tr>
<tr>
<td>Psychiatric admissions to a general acute care hospital apply the inpatient hospital cost sharing. The inpatient mental health cost sharing applies only to stays at free-standing psychiatric hospitals.</td>
<td></td>
</tr>
</tbody>
</table>
### Inpatient hospital care (continued)

- If Healthfirst CompleteCare provides transplant services at a location outside the pattern of care for transplants in your community and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of all blood components begins with the first pint.
- Physician services

**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient mental health care</strong></td>
<td><strong>$0 deductible.</strong></td>
</tr>
<tr>
<td>Covered services include mental health care services that require a hospital stay.</td>
<td><strong>$0 copay per day for unlimited inpatient days as medically necessary.</strong></td>
</tr>
<tr>
<td>You are only covered for up to 190 days inpatient services in a free-standing psychiatric hospital in a lifetime (this lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital).</td>
<td>You will not be charged additional cost sharing for professional services.</td>
</tr>
<tr>
<td>However, as a dual eligible member, you are covered in full for unlimited inpatient mental health days, as medically necessary, beyond the 190-day lifetime Medicare limit.</td>
<td>Prior authorization from the Healthfirst Utilization Management department is only required for elective admissions, not emergency admissions.</td>
</tr>
<tr>
<td>Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.</td>
<td>However, the admitting physician/ facility is encouraged to contact Healthfirst as soon as possible following an emergent admission to ensure appropriate post-stabilization care and discharge planning.</td>
</tr>
<tr>
<td></td>
<td>Psychiatric admissions to a general acute care hospital apply the inpatient hospital cost sharing. The inpatient mental health cost sharing applies only to stays at freestanding psychiatric hospitals.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Inpatient mental health care (continued)</strong></td>
<td>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</td>
</tr>
</tbody>
</table>

| **Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay** | $0 copay for primary care provider (PCP) and specialist services. |
| As described in this Benefits Chart, the plan covers unlimited days as medically necessary for inpatient hospital care and skilled nursing facility (SNF) care. |
| If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include but are not limited to: |

- Physician services
- Diagnostic tests (like lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- $0 copay for laboratory services.
- $0 copay for diagnostic procedures and tests.
- $0 copay for X-rays.
- $0 copay for diagnostic and therapeutic radiology services.
- $0 copay for medical and surgical supplies (such as dressings, splints, casts and other devices used to reduce fractures and dislocations.)

2019 Evidence of Coverage for Healthfirst CompleteCare
Chapter 4: Benefits Chart (what is covered)
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient services covered during a non-covered inpatient stay (continued)</strong></td>
<td><strong>$0 copay for prosthetic devices, and DME.</strong></td>
</tr>
<tr>
<td>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition</td>
<td><strong>$0 copay for physical, speech/language, and occupational therapy services. Prior authorization from Healthfirst’s musculoskeletal delegated vendor is required.</strong></td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy</td>
<td><strong>Prior Authorization from the Healthfirst Utilization Management department is required.</strong></td>
</tr>
</tbody>
</table>


Certain radiology services may also require prior authorization (the ordering physician should contact the radiology vendor for details).
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical nutrition therapy</strong></td>
<td></td>
</tr>
<tr>
<td>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor.</td>
<td></td>
</tr>
<tr>
<td>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.</td>
<td></td>
</tr>
<tr>
<td>$0 copay</td>
<td></td>
</tr>
<tr>
<td>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medicare Diabetes Prevention Program (MDPP)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</td>
<td></td>
</tr>
<tr>
<td>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</td>
<td></td>
</tr>
<tr>
<td>There is no coinsurance, copayment, or deductible for the MDPP benefit.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medicare Part B prescription drugs</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</td>
<td></td>
</tr>
<tr>
<td>- Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</td>
<td></td>
</tr>
<tr>
<td>- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan</td>
<td></td>
</tr>
<tr>
<td>$0 copay for Part-B covered chemotherapy drugs and other Part-B covered drugs.</td>
<td></td>
</tr>
<tr>
<td>Prior authorization from the Healthfirst Utilization Management Department is required.</td>
<td></td>
</tr>
</tbody>
</table>
Services that are covered for you

<table>
<thead>
<tr>
<th>Medicare Part B prescription drugs (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clotting factors you give yourself by injection if you have hemophilia</td>
</tr>
<tr>
<td>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</td>
</tr>
<tr>
<td>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</td>
</tr>
<tr>
<td>• Antigens</td>
</tr>
<tr>
<td>• Certain oral anti-cancer drugs and anti-nausea drugs</td>
</tr>
<tr>
<td>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents</td>
</tr>
<tr>
<td>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</td>
</tr>
<tr>
<td>• Step therapy may apply</td>
</tr>
</tbody>
</table>

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity screening and therapy to promote sustained weight loss</td>
</tr>
<tr>
<td>$0 copay</td>
</tr>
</tbody>
</table>

If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.

There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td>$0 copay for X-rays.</td>
</tr>
<tr>
<td>• X-rays</td>
<td>$0 copay for diagnostic radiology, procedures, and tests.</td>
</tr>
<tr>
<td>• Radiation (radium and isotope) therapy including technician materials and supplies</td>
<td>$0 copay for therapeutic radiology services.</td>
</tr>
<tr>
<td>• Surgical supplies, such as dressings</td>
<td>$0 copay for medical and surgical supplies.</td>
</tr>
<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations</td>
<td>$0 copay for laboratory services.</td>
</tr>
<tr>
<td>• Laboratory tests</td>
<td>$0 copay for each pint of blood (beginning with the first pint).</td>
</tr>
<tr>
<td>• Blood - including storage and administration. Coverage of all blood components begins with the first pint of blood that you need.</td>
<td></td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests such as Gastrointestinal Endoscopy, Spirometry, etc.</td>
<td></td>
</tr>
<tr>
<td>• Diagnostic radiology (e.g., MRIs, PET scans, etc.)</td>
<td>Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
<tr>
<td>Certain radiology services may also require prior authorization (the ordering physician should contact the radiology vendor for details).</td>
<td></td>
</tr>
</tbody>
</table>
## Services that are covered for you

### Outpatient hospital services

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can’t give yourself

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at [https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf](https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

### What you must pay when you get these services

- $0 copay for each outpatient hospital visit.
- Prior authorization from the Healthfirst Utilization Management department is required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient mental health care</strong></td>
<td>$0 copay for each individual or group therapy visit.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td>Prior Authorization is required only for Electroconvulsive Therapy (ECT), Psychological testing, Cognitive skills testing, Comprehensive Psychiatric Emergency Programs (CPEPs), and Neuropsychological testing.</td>
</tr>
<tr>
<td>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient rehabilitation services</th>
<th>$0 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services include: physical therapy, occupational therapy, and speech language therapy.</td>
<td>Prior authorization from Healthfirst’s musculoskeletal delegated vendor is required.</td>
</tr>
<tr>
<td>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</td>
<td></td>
</tr>
<tr>
<td>As a dual eligible member, you are entitled to additional Medicaid-covered services of 40 visits per year for physical therapy and 20 visits per year for occupational therapy, and speech language therapy except when under age 21 or determined to be developmentally disabled by the Office for People with Developmental Disabilities or if you have a traumatic brain injury.</td>
<td></td>
</tr>
<tr>
<td>Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient substance abuse services</strong>&lt;br&gt;Outpatient mental health care for the diagnosis of, treatment for, and counseling for substance abuse.</td>
<td>$0 copay for each individual or group therapy visit.</td>
</tr>
<tr>
<td><strong>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</strong>&lt;br&gt;Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”&lt;br&gt;$0 copay for each ambulatory surgical center or outpatient hospital facility visit.</td>
<td>Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
<tr>
<td><strong>Over-the-Counter (OTC) Non-Prescription Drug Coverage – Healthfirst OTC Card</strong>&lt;br&gt;As a member of Healthfirst CompleteCare, you receive a Healthfirst OTC card with an annual maximum amount for purchasing Healthfirst approved non-prescription, over-the-counter drugs and health-related items at participating locations. No prescription is needed prior to purchasing Healthfirst approved over-the-counter drugs and health-related items. However, some “dual purpose” items such as vitamins, minerals, supplements, hormone replacements, weight loss items, and diagnostic tools (i.e., blood pressure monitors) can only be purchased after a discussion with your provider who verbally recommends the OTC item for a specific diagnosable condition. OTC items may only be purchased for the enrollee, not for family members or friends.</td>
<td>$0 copay&lt;br&gt;Covered in full up to $1,440 per year ($120 per month) for Healthfirst approved non-prescription, over-the-counter drugs and health related items purchased at participating locations.</td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Over-the-Counter (OTC) Non-Prescription Drug Coverage – Healthfirst OTC Card (continued)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The Healthfirst OTC card is not a debit or credit card and cannot be converted to cash, nor can it be used to purchase Part B or Part D covered prescription drugs.</td>
</tr>
</tbody>
</table>

**Unused balances automatically expire each month. Any unused balances automatically expire at the end of the calendar year on December 31st, or upon disenrollment from Healthfirst CompleteCare.**

In addition, as a dual eligible member with full Medicaid benefits, you may be entitled to additional over-the-counter drugs and health-related items. Please contact Member Services at the number on the back of this booklet for more information.

For a comprehensive listing of Healthfirst approved nonprescription, over-the-counter drugs and health-related items, and for more details about how to activate and use your Healthfirst OTC card, please see our website at [www.healthfirst.org/medicare](http://www.healthfirst.org/medicare) or contact Member Services.

Some Over the Counter items may be available to you through Medicaid when you use your Medicaid Benefit Card.

<table>
<thead>
<tr>
<th><strong>Partial hospitalization services</strong></th>
</tr>
</thead>
</table>

“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.

Day treatment and continuing day treatment programs, which do not provide medically supervised psychiatric treatment at the same level of intensity as the medical and nursing services provided in an inpatient setting, are not covered.

$0 copay

Prior authorization from the Healthfirst Utilization Management department is required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician/Practitioner services, including doctor's office visits</strong></td>
<td>$0 copay for each primary care provider (PCP) and specialist office visit.</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</td>
<td></td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist</td>
<td></td>
</tr>
<tr>
<td>• Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment</td>
<td></td>
</tr>
<tr>
<td>• Second opinion by another network provider prior to surgery</td>
<td></td>
</tr>
<tr>
<td>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry services</strong></td>
<td></td>
</tr>
<tr>
<td>Covered services include:</td>
<td>$0 copay for those podiatry services performed in a doctor's office.</td>
</tr>
<tr>
<td>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</td>
<td>Podiatry services that involve surgery in an ambulatory surgery facility or outpatient hospital setting will apply different cost-sharing. See those sections for more information. This plan covers 12 routine visits per year.</td>
</tr>
<tr>
<td>• Routine foot care for members with certain medical conditions affecting the lower limbs</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Prostate cancer screening exams</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>For men age 50 and older, covered services include the following - once every 12 months:</td>
<td>There is no coinsurance, copayment, or deductible for an annual PSA test.</td>
</tr>
<tr>
<td>- Digital rectal exam</td>
<td></td>
</tr>
<tr>
<td>- Prostate Specific Antigen (PSA) test</td>
<td></td>
</tr>
</tbody>
</table>

| **Prosthetic devices and related supplies** | $0 copay for prosthetic devices. |
| Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. | $0 copay for Medicare-covered eyewear after cataract removal. |
| As a dual eligible member, you are entitled to additional Medicaid-covered covered prosthetics, orthotics and orthopedic footwear. | Prior authorization from the Healthfirst Utilization Management department is required for prosthetic devices. |
| Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail. |                                               |

| **Pulmonary rehabilitation services** | $0 copay                                      |
| Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. | Prior authorization from the Healthfirst Utilization Management department is required. |
### Services that are covered for you

#### Screening and counseling to reduce alcohol misuse

We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren’t alcohol dependent.

If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.

**$0 copay**

There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

### Screening for lung cancer with low dose computed tomography (LDCT)

For qualified individuals, a LDCT is covered every 12 months.

**Eligible members are:** people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

**For LDCT lung cancer screenings after the initial LDCT screening:** the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

**$0 copay**

There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.
## Services that are covered for you

### Screening for sexually transmitted infections (STIs) and counseling to prevent STIs

We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.

We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 copay</td>
</tr>
</tbody>
</table>

There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

## Services to treat kidney disease

Covered services include:

- Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.
- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)
- Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 copay for renal dialysis</td>
</tr>
</tbody>
</table>

$0 copay for nutrition therapy for end-stage renal disease (ESRD).

Prior authorization from the Healthfirst Utilization Management department is required for dialysis services.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>

### Services to treat kidney disease (continued)

Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, “Medicare Part B prescription drugs.”

### Skilled nursing facility (SNF) care

(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)

A 3-day prior hospital stay is not required.

Medicare limits coverage to 100 days each benefit period. However, as a dual eligible member, you are covered for additional days beyond the Medicare-defined 100 day limit.

Covered services include but are not limited to:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration. Coverage of all blood components begin with the first pint.
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

$0 copay

You will not be charged additional cost sharing for professional services.

Prior authorization from the Healthfirst Utilization Management department is required.
Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility (SNF) care (continued)</td>
<td></td>
</tr>
<tr>
<td>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn’t a network provider, if the facility accepts our plan’s amounts for payment.</td>
<td></td>
</tr>
<tr>
<td>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).</td>
<td></td>
</tr>
<tr>
<td>• A SNF where your spouse is living at the time you leave the hospital.</td>
<td></td>
</tr>
<tr>
<td>Please refer to the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.</td>
<td></td>
</tr>
</tbody>
</table>

Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)

If you use tobacco, we cover up to eight (8) face-to-face smoking cessation counseling visits per year.

$0 copay

There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
</table>
| **Supervised Exercise Therapy (SET)**

SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.

Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.

The SET program must:

- Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication
- Be conducted in a hospital outpatient setting or a physician’s office
- Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD
- Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques

SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.

$0 copay for supervised exercise therapy services.

Prior authorization from the Healthfirst Utilization Management department is required.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation (Routine/Non-Emergent)</strong></td>
<td>$0 copay for unlimited round trips to an approved provider location.</td>
</tr>
<tr>
<td>We will arrange for round-trip car service to an approved provider location. You must call Healthfirst CompleteCare Member Services at least two days in advance of your office visit and Healthfirst CompleteCare will arrange to have you transported by an approved car service. You will not be reimbursed for the cost of transportation which is not prior-authorized by Healthfirst CompleteCare other than public transportation. Transportation to out-of-network providers is not covered unless medically-necessary and prior-authorized by Healthfirst CompleteCare for example, when network providers are unavailable or inaccessible, or unable to provide the level or type of care that Medicare requires our plan to cover). As a dual eligible member you are entitled to the following Medicaid process: If you prefer to take public transportation (i.e., MTA transit, including subway, bus, Long Island Rail Road, and/or Metro-North Rail Road, etc.), you must submit a completed Medicare Reimbursement form to Healthfirst CompleteCare in order for you to receive reimbursement for the cost of the round trip. A copy of the Member Reimbursement form is available online at <a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a>, or call Member Services and request a copy of the form (phone numbers are on the back of this booklet). Please refer the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.</td>
<td>You must call Healthfirst CompleteCare Member Services for authorization at least two (2) days in advance.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Urgently needed services</td>
<td>$0 copay for each urgent care visit</td>
</tr>
<tr>
<td>Urgently needed services are</td>
<td>$0 copay for Worldwide Urgent Care Services</td>
</tr>
<tr>
<td>provided to treat a non-</td>
<td>The maximum coverage limit amount for</td>
</tr>
<tr>
<td>emergency, unforeseen medical</td>
<td>emergency and urgent care outside the U.S. is</td>
</tr>
<tr>
<td>illness, injury, or condition</td>
<td>$100,000 per year.</td>
</tr>
<tr>
<td>that requires immediate medical</td>
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</tr>
<tr>
<td>care. Urgently needed services</td>
<td></td>
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<tr>
<td>may be furnished by network</td>
<td></td>
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<tr>
<td>providers or by out-of-network</td>
<td></td>
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<tr>
<td>providers when network providers</td>
<td></td>
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<tr>
<td>are temporarily unavailable or</td>
<td></td>
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<tr>
<td>inaccessible.</td>
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<tr>
<td>Cost sharing for necessary</td>
<td></td>
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<tr>
<td>urgently needed services</td>
<td></td>
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<tr>
<td>furnished out-of-network</td>
<td></td>
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<tr>
<td>is the same as for such services</td>
<td></td>
</tr>
<tr>
<td>furnished in-network.</td>
<td></td>
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<tr>
<td>Coverage is worldwide.</td>
<td></td>
</tr>
<tr>
<td>Worldwide coverage is only for</td>
<td></td>
</tr>
<tr>
<td>emergency, urgently needed</td>
<td></td>
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<tr>
<td>services and emergency</td>
<td></td>
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<tr>
<td>transportation. To get emergency</td>
<td></td>
</tr>
<tr>
<td>care or urgently needed services</td>
<td></td>
</tr>
<tr>
<td>furnished in other countries</td>
<td></td>
</tr>
<tr>
<td>reimbursed by Healthfirst, you'll</td>
<td></td>
</tr>
<tr>
<td>need to give a Healthfirst</td>
<td></td>
</tr>
<tr>
<td>Member Services Representative</td>
<td></td>
</tr>
<tr>
<td>an itemized proof of payment</td>
<td></td>
</tr>
<tr>
<td>and medical record of the care</td>
<td></td>
</tr>
<tr>
<td>received. Healthfirst CompleteCare will not cover any Part D prescription drugs that you receive as part of your emergency or urgent care visit in another country.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
</tbody>
</table>

**Vision care**

Covered services include:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn’t cover routine eye exams (eye refractions) for eyeglasses/contacts.
- For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older.
- For people with diabetes, screening for diabetic retinopathy is covered once per year.
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)

Medicare-covered benefits do not include routine vision exams, eyeglasses or contact lenses (other than one pair of eyeglasses or contact lenses following cataract surgery as described above).

However, as a Healthfirst CompleteCare member, you are entitled to additional vision benefits not otherwise covered under Original Medicare.

Additional benefits include one routine eye exam, including annual glaucoma screenings (for those at high risk) and one pair of eyeglasses or contact lenses every year as follows:

- **$0 copay for Medicare-covered eye exams**, including diagnosis and treatment for diseases and conditions of the eye.
- **$0 copay for one (1) routine eye exam per year**, including annual glaucoma screenings for those at high risk.
- **$0 copay for corrective frames/lenses needed after cataract removal.**
- **$0 copay for one (1) pair of glasses (standard lenses) from the “Fashion Frame” collection or contact lenses every year.**
- **Enhanced frame options:**
  - **$20 copay for “Designer” Collection frames.**
  - **$45 copay for “Premier” Collection frames.**
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision care (continued)</strong></td>
<td>* Enhanced lens options:</td>
</tr>
<tr>
<td><em>Eye wear covered services include:</em></td>
<td>$55 copay for standard progressive lenses.</td>
</tr>
<tr>
<td>• One (1) pair of contact lenses or eyeglasses (frames and lenses) every year with no prior Medicare-defined cataract surgery requirement.</td>
<td>$95 copay for premium progressive lenses.</td>
</tr>
<tr>
<td>• The plan’s exclusive collection features three (3) levels of frames:</td>
<td>$140 copay for ultra (or digital) progressive lenses.</td>
</tr>
<tr>
<td>- Fashion Frames: $0 copay</td>
<td>$35 copay for polycarbonate lenses.</td>
</tr>
<tr>
<td>- Designer Frames: $20 copay*</td>
<td>$40 copay for standard anti-reflective coating lenses.</td>
</tr>
<tr>
<td>- Premier Frames: $45 copay*</td>
<td>$53 copay for premium anti-reflective coating lenses.</td>
</tr>
<tr>
<td>• Non-plan frames or contact lenses selected outside of the plan’s exclusive collection and from the provider’s own supply are subject to a $100 maximum coverage limit.</td>
<td>$65 copay for ultra-anti-reflective coating lenses.</td>
</tr>
<tr>
<td>• Standard lens coverage is limited to the following:</td>
<td>$35 copay for intermediate vision lenses.</td>
</tr>
<tr>
<td>- Plastic or glass single vision, bifocal or trifocal lenses (in any prescription range), glass grey #3 prescription lenses, oversize lenses, post-cataract lenses, sun or gradient tinted plastic lenses, Photogrey Extra® (photosensitive) glass lenses, and polycarbonate lenses (for monocular patients and patients with prescriptions +/- 6.00 diopters or greater).</td>
<td>$80 copay for polarized lenses.</td>
</tr>
</tbody>
</table>

Please refer the Healthfirst CompleteCare Medicaid Advantage Plus Handbook for additional benefits available under the Medicaid Advantage Plus Plan.

*Note: Designer or Premier Frames, Enhanced Lens or Frames options are not included features of our additional vision benefits. However, through an arrangement with our vision vendor, Healthfirst is able to offer these additional features at significantly reduced costs to our members. Therefore these copays do not count towards your annual Medicare Maximum Out-of-Pocket (MOOP) cost.*
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vision care (continued)</strong></td>
<td><strong>Enhanced lens options (continued):</strong> $60 copay for high-index lenses. $25 copay for scratch-resistant lens coating. $17 copay for ultraviolet (UV) lens coating. Prior Authorization is required for medically necessary contact lenses, replacement for lost/stolen glasses outside the warranty period, or if the member has a .5 diopter change in vision.</td>
</tr>
</tbody>
</table>

**Web/Phone Based Technologies**

As a member of CompleteCare, you have access to a doctor either by phone, secure video through your personal computer, or using a mobile device such as a tablet 24 hours a day, 7 days a week. Doctors can diagnose symptoms, prescribe medication, and send prescriptions to a selected pharmacy. The program is designed to handle non-emergency medical issues and should not be used when experiencing a medical emergency. While this program is not intended to replace your primary care doctor for common or chronic conditions, a virtual doctor’s appointment can sometimes be another option when your doctor’s office or urgent care center is not available or open. You must follow-up with your primary care doctor for any treatment provided by this service. You are not required to use this service, and you can contact your primary care doctor to request an appointment. You can call **Teladoc** to learn more about your benefit at 1-800-TELADOC (1-800-835-2362) TTY 1-800-877-8973 7 days a week, 24 hours a day.
“Welcome to Medicare” Preventive Visit

The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

**Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.

### $0 copay

There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

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### Additional Medicaid-covered benefits for Healthfirst CompleteCare members

Healthfirst CompleteCare is a Fully Integrated Dual Eligible Special Needs Plan that combines Medicare coverage with Medicaid benefits including additional long-term care services, specifically designed for members who require nursing home level of care.

The following chart lists the additional Medicaid benefits and services available for Healthfirst CompleteCare members. In most cases, you will use your Healthfirst CompleteCare member identification (ID) card to receive the additional benefits described in this section. However, some benefits described (in the next section) are only covered by New York State Fee-For-Service Medicaid, and not Healthfirst CompleteCare. You will need to use your New York State issued Medicaid Card when accessing the services that are only covered by New York State Fee-For-Service Medicaid.
### Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) skill acquisition, maintenance, and enhancement **

These services and supports are intended to help you make the most of your independence and/or being in the community. They address skills you need to perform ADLs and IADLs.

These services may include assessment, training, supervision, cueing, or hands-on assistance to help you with specific tasks, such as:

- self-care
- life safety
- medication management
- communication
- mobility
- community transportation
- community integration
- inappropriate social behaviors
- money management
- maintaining a household

Depending on your assessed need and when you reasonably can be expected to learn to perform the task(s) independently, these services may be:

- time limited,
- extended, or
- changed in scope from hands-on assistance to supervision and cueing

You can get these services in any setting that does not already offer you some form of paid human assistance. For example, such a setting might include your home or work setting.

<table>
<thead>
<tr>
<th>Additional Medicaid-Covered Benefits</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) skill acquisition, maintenance, and enhancement **</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Activity of Daily Living (ADL) and Instrumental Activity of Daily Living (IADL) skill acquisition, maintenance, and enhancement ** (continued)</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Direct care workers such as home health aides, personal care providers, personal attendants, and personal assistants under the Agency with Choice Model (CDPAS) may provide these services. Providers must have the appropriate training, certification, or licensure for the services authorized for you. Note: These services cannot be substituted for vocational rehabilitation services provided under the Rehabilitation Act of 1973.</td>
<td></td>
</tr>
<tr>
<td>Services require determination of medical necessity and prior authorization.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assistive Technology (AT) beyond the scope of Durable Medical Equipment **</th>
<th>$0 copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Piece of equipment, product system or instrument of technology, whether mechanical or electrical and whether acquired commercially, modified, or customized. Examples of AT include but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>- Motion/sound, toilet flush, incontinence and fall sensors</td>
<td></td>
</tr>
<tr>
<td>- Automatic faucet and soap dispensers</td>
<td></td>
</tr>
<tr>
<td>- Two-way communication systems</td>
<td></td>
</tr>
<tr>
<td>- Augmentative communication aids and devices</td>
<td></td>
</tr>
<tr>
<td>- Adaptive aids and devices</td>
<td></td>
</tr>
<tr>
<td>The utilization threshold for Assistive Technology is $15,000 per 12-month period.</td>
<td></td>
</tr>
<tr>
<td>Services require determination of medical necessity and prior authorization.</td>
<td></td>
</tr>
</tbody>
</table>
### Additional Medicaid-Covered Benefits

<table>
<thead>
<tr>
<th>Benefits</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Day Health Care</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Adult day health care is care and services provided in a residential health care facility or approved extension site under the medical direction of a physician to a person who is functionally impaired, not homebound, and who requires certain preventive, diagnostic, therapeutic, rehabilitative or palliative items or services, and includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, which are a planned program of diverse meaningful activities, dental, pharmaceutical, and other ancillary services, and includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services.</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Community Transitional Services</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>This service is intended to assist the member who is transitioning from an institutional setting to a home in the community where s/he will reside. This service covers expenses related to setting up a household such as:</td>
<td>$0 copay</td>
</tr>
<tr>
<td>• Payment of the first and last month’s rent</td>
<td></td>
</tr>
<tr>
<td>• Utility and rental deposits (security, broker leasing fees, set-up fees for heat, electricity, telephone)</td>
<td></td>
</tr>
<tr>
<td>• The purchase of basic essential household items such as furniture, linens, and kitchen supplies</td>
<td></td>
</tr>
<tr>
<td>Health and safety assurances such as pest removal, allergen control, or one-time cleaning prior to occupancy.</td>
<td></td>
</tr>
<tr>
<td>The utilization threshold for Community Transitional Services is a $5,000 one-time expense.</td>
<td></td>
</tr>
<tr>
<td>This service is limited to transitioning from a nursing facility, Institution for Mental Disease (IMD) or Intermediate Care Facility for the Developmentally Disabled (ICF/DD) to your home or the home of a family member where you will reside.</td>
<td></td>
</tr>
<tr>
<td>Services are provided based on medical necessity and upon authorization.</td>
<td></td>
</tr>
</tbody>
</table>
Environmental Modifications (E-mods)**

This service encompasses internal and external adaptations to your residence when the adaptations are beyond the scope of what is currently covered under the social and environmental supports benefit. The adaptations must be identified in the PCSP as being necessary to enable you to function with greater independence in your home or to substitute for human assistance that would otherwise be authorized (e.g., personal care services). Adaptations covered under this service include but are not limited to:

Hydraulic, manual or electric lifts (or rented lifts if they are more cost effective)
- Widened doorways and hallways
- Roll-in showers
- Modifications of the bathrooms
- Cabinet and shelving adaptations
- Hand rails and grab bars
- Ramps
- Automatic or manual door openers and doorbells
- Water faucet controls
- Specialized electrical and plumbing system changes required to accommodate new equipment or supplies

This service does not include home improvements such as air conditioning, new carpet, roof repair, etc. that are unrelated to the PCSP. However, home improvement services and items previously included under social and environmental supports are now covered as a CFCO benefit under environmental modifications.

The utilization threshold for Environmental Modifications is $15,000 per 12-month period.

Services require determination of medical necessity and prior authorization.
<table>
<thead>
<tr>
<th>Additional Medicaid-Covered Benefits</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>**Home Delivered and Congregate Meals ***</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or to have them prepared.</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Social Services</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Medically necessary assessment, arranging and providing aid for social problems related to maintaining an individual at home.</td>
<td></td>
</tr>
<tr>
<td><strong>Moving Assistance</strong>**</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Moving Assistance is available if you are transitioning from an institutional setting to a community-based setting. This service covers the cost of physically moving furnishings and other belongings to the community-based setting where you will reside. The utilization threshold for Moving Assistance is a $5,000 one-time expense. Services require determination of medical necessity and prior authorization.</td>
<td></td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Assessment of nutritional status/needs, development and evaluation of treatment plans, nutritional education, in-service education, and includes cultural considerations.</td>
<td></td>
</tr>
<tr>
<td>Additional Medicaid-Covered Benefits</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Personal Care Services</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Includes medically necessary assistance with Activities of Daily Living (ADLs). Instrumental Activities of Daily Living (IADLs) and health-related tasks through hands-on assistance, supervision, and/or cueing.</td>
<td></td>
</tr>
<tr>
<td>Personal care services require a physician’s order, prior approval, and must be medically necessary.</td>
<td></td>
</tr>
<tr>
<td><strong>Personal Emergency Response Services (PERS)</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.</td>
<td></td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong></td>
<td>$0 copay</td>
</tr>
<tr>
<td>This type of service provides home care aides, companion care, and homemaker services and may include nursing services in your home or place of residence. This is in accordance with the ordering physician, registered physician assistant or certified nurse practitioner’s written treatment plan.</td>
<td></td>
</tr>
<tr>
<td>Private duty nursing services must be provided by a person possessing a license and current registration from the New York State Education Department to practice as a registered professional nurse or licensed practical nurse.</td>
<td></td>
</tr>
<tr>
<td>**Social and Environmental Supports ***</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Services and items to support member’s medical needs. May include home maintenance tasks, homemaker/chore services, housing improvements and respite care.</td>
<td></td>
</tr>
</tbody>
</table>
Additional Medicaid-Covered Benefits

Social Day Care *
Structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.

What you must pay when you get these services

Social Day Care *
Structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance.

What you must pay when you get these services

Vehicle Modification**
This service covers the cost of modifications to a vehicle if it is your primary means of transportation. The vehicle may be owned by you or by a family member or non-relative who provides primary, consistent and ongoing transportation for you. Modifications are approved only when they are necessary to increase independence and inclusion in the community. Modifications that might enable you to operate a vehicle include but are not limited to:

- Hand controls
- Deep dish steering wheel
- Spinner knobs
- Wheelchair lock downs
- Parking brake extensions
- Foot controls
- Wheelchair lifts (including maintenance contracts)
- Left foot gas pedals

Additionally, modifications to the structure and internal design of a vehicle that are performed to meet specific might include:

- Floor cut-outs
- Replacement of a roof with a fiberglass top
- Extension of steering column
- Raised door
- Repositioning of seats
- Wheelchair floor
- Dashboard adaptions

Vehicle Modification**
This service covers the cost of modifications to a vehicle if it is your primary means of transportation. The vehicle may be owned by you or by a family member or non-relative who provides primary, consistent and ongoing transportation for you. Modifications are approved only when they are necessary to increase independence and inclusion in the community. Modifications that might enable you to operate a vehicle include but are not limited to:

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- Floor cut-outs
- Replacement of a roof with a fiberglass top
- Extension of steering column
- Raised door
- Repositioning of seats
- Wheelchair floor
- Dashboard adaptions

$0 copay

$0 copay
### Additional Medicaid-Covered Benefits

### Vehicle Modification** (continued)

The utilization threshold for Vehicle Modifications is $15,000 per 12-month period.

Services require determination of medical necessity and prior authorization.

* denotes that these benefits are not covered under FFS Medicaid but are covered under Healthfirst CompleteCare

** denotes that you may be eligible to receive these additional Community First Choice Option (CFCO) services as a Healthfirst CompleteCare member if you:
- Are 21 years of age or older;
- Require a nursing home level of care (NH LOC) as determined using the State’s designated assessment tool, currently the Uniform Assessment System (UAS) assessment, or an institutional level of care;
- Are able to live safely in the community if s/he receives CFCO services; and
- Live in your own residence or the residence of a family member.
**SECTION 3**  What services are covered outside of Healthfirst CompleteCare

**Section 3.1**  Services *not* covered by Healthfirst CompleteCare

The following services are not covered by Healthfirst CompleteCare but are available through Fee-For-Service Medicaid.

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS Adult Day Health Care</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Assisted Living Program</td>
<td>$0 copay</td>
</tr>
<tr>
<td><strong>Certain Mental Health Services, including</strong></td>
<td></td>
</tr>
<tr>
<td>o Intensive Psychiatric Rehabilitation Treatment Programs</td>
<td>$0 copay</td>
</tr>
<tr>
<td>o Day Treatment</td>
<td></td>
</tr>
<tr>
<td>o Continuing Day Treatment</td>
<td></td>
</tr>
<tr>
<td>o Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)</td>
<td></td>
</tr>
<tr>
<td>o Partial Hospitalizations</td>
<td></td>
</tr>
<tr>
<td>o Assertive Community Treatment (ACT)</td>
<td></td>
</tr>
<tr>
<td>o Personalized Recovery Oriented Services (PROS)</td>
<td></td>
</tr>
<tr>
<td>Directly Observed Therapy for Tuberculosis Disease</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Hospice services provided to Medicare Advantage members</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Home and Community Based Waiver Program Services</td>
<td>$0 copay</td>
</tr>
<tr>
<td>Medicaid Pharmacy Benefits as allowed by State Law</td>
<td>$0 copay</td>
</tr>
<tr>
<td>(select drug categories excluded from the Medicare Part D benefit)</td>
<td></td>
</tr>
<tr>
<td>Methadone Maintenance Treatment Programs</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>
### Office for People with Developmental Disability Services

$0$ copay

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

$0$ copay

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

$0$ copay

## SECTION 4

### What services are not covered by the plan or Medicaid?

**Section 4.1** Services *not covered by the plan (exclusions) OR Medicaid*

This section tells you what services are “excluded.” Excluded means that the plan doesn’t cover these services.

The chart below describes some services and items that aren’t covered by the plan under any conditions or are covered by the plan only under specific conditions.

We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this booklet.)
All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

<table>
<thead>
<tr>
<th>Services not covered by Medicare</th>
<th>Not covered under any condition</th>
<th>Covered only under specific conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services considered not reasonable and necessary, according to the standards of Original Medicare</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.</td>
<td></td>
<td>May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)</td>
</tr>
<tr>
<td>Private room in a hospital.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Full-time nursing care in your home.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.</td>
<td></td>
<td>√</td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Homemaker services include basic household assistance, including light housekeeping or light meal preparation.</td>
<td></td>
<td>May be covered through your additional long-term care services only when deemed medically necessary.</td>
</tr>
<tr>
<td>Fees charged for care by your immediate relatives or members of your household.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery or procedures</td>
<td></td>
<td>• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.</td>
</tr>
<tr>
<td>Routine chiropractic care</td>
<td></td>
<td>Manual manipulation of the spine to correct a subluxation is covered.</td>
</tr>
<tr>
<td>Orthopedic shoes</td>
<td></td>
<td>If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.</td>
</tr>
<tr>
<td>Services not covered by Medicare</td>
<td>Not covered under any condition</td>
<td>Covered only under specific conditions</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Supportive devices for the feet</td>
<td></td>
<td>√ Orthopedic or therapeutic shoes for people with diabetic foot disease, or as covered under the additional Medicaid-covered benefits.</td>
</tr>
<tr>
<td>LASIK surgery, radial keratotomy and keratoplasty to treat refractive defects.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Reversal of sterilization procedures and or non-prescription contraceptive supplies.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Naturopath services (uses natural or alternative treatments).</td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.*
CHAPTER 5

Using the plan’s coverage for your Part D prescription drugs
Chapter 5. Using the plan's coverage for your Part D prescription drugs

SECTION 1  Introduction ........................................................................................................ 121
Section 1.1 This chapter describes your coverage for Part D drugs .................. 121
Section 1.2 Basic rules for the plan's Part D drug coverage ......................... 122

SECTION 2  Fill your prescription at a network pharmacy or through the plan's mail-order service ........................................ 122
Section 2.1 To have your prescription covered, use a network pharmacy ..... 122
Section 2.2 Finding network pharmacies ................................................................. 123
Section 2.3 Using the plan's mail-order services .............................................. 124
Section 2.4 How can you get a long-term supply of drugs? ......................... 125
Section 2.5 When can you use a pharmacy that is not in the plan's network? .................................................. 125

SECTION 3  Your drugs need to be on the plan's "Drug List" ................. 126
Section 3.1 The "Drug List" tells which Part D drugs are covered............. 126
Section 3.2 How can you find out if a specific drug is on the Drug List? ...... 128

SECTION 4  There are restrictions on coverage for some drugs .......... 128
Section 4.1 Why do some drugs have restrictions? ........................................ 128
Section 4.2 What kinds of restrictions? ............................................................... 128
Section 4.3 Do any of these restrictions apply to your drugs? ...................... 129

SECTION 5  What if one of your drugs is not covered in the way you'd like it to be covered? ............................................ 130
Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered .............................. 130
Section 5.2  What can you do if your drug is not on the Drug List or if the drug is restricted in some way? ................................................................. 130

SECTION 6  What if your coverage changes for one of your drugs? ....... 133

Section 6.1  The Drug List can change during the year .......................... 133

Section 6.2  What happens if coverage changes for a drug you are taking? .. 133

SECTION 7  What types of drugs are not covered by the plan? .............. 135

Section 7.1  Types of drugs we do not cover ............................................. 135

SECTION 8  Show your plan membership card when you fill a prescription ................................................................................................. 136

Section 8.1  Show your membership card ............................................... 136

Section 8.2  What if you don’t have your membership card with you? ....... 137

SECTION 9  Part D drug coverage in special situations ...................... 137

Section 9.1  What if you’re in a hospital or a skilled nursing facility for a stay that is covered by the plan? ......................................................... 137

Section 9.2  What if you’re a resident in a long-term care (LTC) facility? .... 137

Section 9.3  What if you’re in a Medicare-certified hospice? ................... 138

SECTION 10  Programs on drug safety and managing medications........... 138

Section 10.1  Programs to help members use drugs safely ...................... 138

Section 10.2  Drug Management Program (DMP) to help members safely use their opioid medications ......................................................... 139

Section 10.3  Medication Therapy Management (MTM) program to help members manage their medications ............................................... 140
How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you. We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

In addition to your coverage for Part D drugs, Healthfirst CompleteCare also covers some drugs under the plan’s medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (Medical Benefits Chart, what is covered) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.3 (What if you’re in Medicare-certified hospice). For information on hospice coverage, see the hospice section of Chapter 4 (Medical Benefits Chart, what is covered).

The following sections discuss coverage of your drugs under the plan’s Part D benefit rules. Section 9, Part D drug coverage in special situations includes more information on your Part D coverage and Original Medicare.
In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For more information about your Medicaid drug coverage please contact New York State Medicaid Program. (You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6).

### Section 1.2 Basic rules for the plan’s Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.

- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy or through the plan’s mail-order service.)

- Your drug must be on the plan’s List of Covered Drugs (Formulary) (we call it the “Drug List” for short). (See Section 3, Your drugs need to be on the plan’s “Drug List.”)

- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

### SECTION 2 Fill your prescription at a network pharmacy or through the plan’s mail-order service

#### Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan’s network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term “covered drugs” means all of the Part D prescription drugs that are covered on the plan’s Drug List.
Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your Provider/Pharmacy Directory, visit our website (www.HFMedicareMaterials.org), or call Member Services (phone numbers are printed on the back of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan’s network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back of this booklet) or use the Provider/Pharmacy Directory.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. Residents may get prescription drugs through the facility’s pharmacy as long as it is part of our network. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)
To locate a specialized pharmacy, look in your Provider/Pharmacy Directory or call Member Services (phone numbers are printed on the back of this booklet).

**Section 2.3 Using the plan’s mail-order services**

For certain kinds of drugs, you can use the plan’s network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan’s mail order services are marked as **NM for not available at Mail order** in our Drug List.

Our plan’s mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply.

To get order forms and information about filling your prescriptions by mail, visit [www.healthfirst.org/medicare](http://www.healthfirst.org/medicare) or call Member Services (phone numbers are on the back of this booklet). If you use a mail-order pharmacy that’s not in the plan’s network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If the mail-order pharmacy expects a delay of more than 14 days, they will contact you and help you decide whether to wait for the medication, cancel the mail order, or fill the prescription at a local pharmacy. If your order does not reach you within 14 days, you may contact Member Services.

**New prescriptions the pharmacy receives directly from your doctor’s office.**

After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

**Refills on mail-order prescriptions.**

For refills of your drugs, you have the option to sign up for an automatic refill program “Ready Fill at Mail.” Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill
program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program “Ready Fill at Mail” that automatically prepares mail order refills, please contact us by visiting www.healthfirst.org/medicare or call Member Services (phone numbers are on the back of this booklet).

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please let us know how you would like to be reached by visiting our website at www.healthfirst.org/medicare or call Member Services (phone numbers are on the back of this booklet).

### Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing may be lower. The plan offers two ways to get a long-term supply (also called an “extended supply”) of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back of this booklet).

2. For certain kinds of drugs, you can use the plan’s network mail-order services. The drugs that are *not* available through the plan’s mail-order service are marked as **NM for not available at Mail order** in our Drug List. Our plan’s mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. See Section 2.3 for more information about using our mail-order services.

### Section 2.5 When can you use a pharmacy that is not in the plan’s network?

**Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:
• Example 1: You are traveling outside of the service area and you run out of or lose your covered Part D drug(s) or become ill and need a covered Part D drug, and you cannot access a network pharmacy.

• Example 2: You cannot obtain a covered Part D drug in a timely manner within the service area because, for example, there is no network pharmacy within a reasonable driving distance that provides 24-hour-a-day/7-day-per-week service.

• Example 3: You must fill a prescription for a covered Part D drug in a timely manner, and that particular covered Part D drug (for example, a specialty pharmaceutical typically shipped directly from manufacturers or special vendors) is not regularly stocked at accessible network retail or mail order pharmacies.

• Example 4: You are provided covered Part D drugs dispensed by an out-of-network institution-based pharmacy while you are a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.

• Example 5: During any Federal disaster declaration or other public health emergency declaration in which our members are evacuated or otherwise displaced from their places of residence and cannot reasonably be expected to obtain covered Part D drugs at a network pharmacy.

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan’s “Drug List”

Section 3.1 The “Drug List” tells which Part D drugs are covered

The plan has a “List of Covered Drugs (Formulary).” In this Evidence of Coverage, we call it the “Drug List” for short.
The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan’s Drug List.

The Drug List includes the drugs covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs). In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For more information about your Medicaid drug coverage please contact New York State Medicaid Program. (You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6).

We will generally cover a drug on the plan’s Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A “medically accepted indication” is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)

- -- or -- Supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; the USPDI or its successor; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

**The Drug List includes both brand name and generic drugs**

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

**What is not on the Drug List?**

The Drug List does not include prescription drugs that are covered for you under your Medicaid benefits. For more information about your Medicaid drug coverage please contact New York State Medicaid Program. (You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6).

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).

- In other cases, we have decided not to include a particular drug on our Drug List.
Section 3.2  How can you find out if a specific drug is on the Drug List?

You have two ways to find out:

1. Visit the plan’s website (www.HFMedicareMaterials.org). The Drug List on the website is always the most current.

2. Call Member Services to find out if a particular drug is on the plan’s Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back of this booklet.)

SECTION 4  There are restrictions on coverage for some drugs

Section 4.1  Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan’s rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare’s rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2  What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.
Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “prior authorization.” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “step therapy.”

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

<table>
<thead>
<tr>
<th>Section 4.3</th>
<th>Do any of these restrictions apply to your drugs?</th>
</tr>
</thead>
</table>

The plan’s Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back of this booklet) or check our website (www.HFMedicareMaterials.org).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the
restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

SECTION 5

What if one of your drugs is not covered in the way you’d like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you’d like it to be covered

We hope that your drug coverage will work well for you. But it’s possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.

There are things you can do if your drug is not covered in the way that you’d like it to be covered.

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 5.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.

- You can change to another drug.
• You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:
   • The drug you have been taking is no longer on the plan’s Drug List.
   • -- or -- the drug you have been taking is now restricted in some way (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:
   • For those members who are new or who were in the plan last year and aren’t in a long-term care (LTC) facility:
     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year. This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills up to a maximum of a 30 day supply of medication. The prescription must be filled at a network pharmacy.
   • For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility and need a supply right away:
     We will cover a temporary supply of your drug during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year. The total supply will be for a maximum of 31 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 31 days of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
• **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

  We will cover one 31-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

• **If you are a current member and you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary or if your ability to get your drugs is limited:**

  We will cover a one-time temporary supply for up to 30-days (or 31-days if you are a long-term care (LTC) resident) from a network pharmacy. During this period, you should use the plan’s exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

**You can change to another drug**

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back of this booklet.)

**You can ask for an exception**

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan’s Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.
SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).

- **Replace a brand name drug with a generic drug.**

We must follow Medicare requirements before we change the plan’s Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we add new restrictions to the brand name drug)**
  - We may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear with the same or fewer restrictions. Also, when adding the new generic drug, we may
decide to keep the brand name drug on our Drug List, but add new restrictions.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug.
- You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
  - Your prescriber will also know about this change, and can work with you to find another drug for your condition.

- **Other changes to drugs on the Drug List**
  - We may make other changes once the year has started that affect drugs you are taking. For instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare. We must give you at least 30 days' notice or give you a 30-day refill of the drug you are taking at a network pharmacy.
  - During this 30-day period, you should be working with your prescriber to switch to a different drug that we cover.
  - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we put a new restriction on your use of the drug
- If we remove your drug from the Drug List

If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won’t affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won’t see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year’s Drug List for any changes to drugs.

SECTION 7 What types of drugs are not covered by the plan?

<table>
<thead>
<tr>
<th>Section 7.1</th>
<th>Types of drugs we do not cover</th>
</tr>
</thead>
</table>

This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

We won’t pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan’s Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. Please contact New York State Medicaid Program to determine what excluded drugs may be available to you. (You can find phone numbers and contact information for New York State Medicaid in Chapter 2, Section 6).

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

SECTION 8  Show your plan membership card when you fill a prescription

Section 8.1  Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for our share of the costs of your covered prescription drug. You will need to pay the pharmacy your share of the cost when you pick up your prescription.
Section 8.2  What if you don’t have your membership card with you?

If you don’t have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9  Part D drug coverage in special situations

Section 9.1  What if you’re in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

Section 9.2  What if you’re a resident in a long-term care (LTC) facility?

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility’s pharmacy as long as it is part of our network.

Check your Provider/Pharmacy Directory to find out if your long-term care facility’s pharmacy is part of our network. If it isn’t, or if you need more information, please contact Member Services (phone numbers are printed on the back of this booklet).

What if you’re a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership. The total supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan
has any restriction on the drug’s coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

### Section 9.3 What if you’re in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

### SECTION 10 Programs on drug safety and managing medications

#### Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.
We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2 Drug Management Program (DMP) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor
- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations with think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See Chapter 9 for information about how to ask for an appeal.
The DMP may not apply to you if you have certain medical conditions, such as cancer, or you are receiving hospice care or live in a long-term care facility.

### Section 10.3 Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take. Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly “Wellness” visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back of this booklet).
CHAPTER 6

What you pay for your Part D prescription drugs
## Chapter 6. What you pay for your Part D prescription drugs

<table>
<thead>
<tr>
<th>SECTION</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction</td>
<td>144</td>
</tr>
<tr>
<td>1.1</td>
<td>Use this chapter together with other materials that explain your drug coverage</td>
<td>144</td>
</tr>
<tr>
<td>1.2</td>
<td>Types of out-of-pocket costs you may pay for covered drugs</td>
<td>145</td>
</tr>
<tr>
<td>2</td>
<td>What you pay for a drug depends on which “drug payment stage” you are in when you get the drug</td>
<td>145</td>
</tr>
<tr>
<td>2.1</td>
<td>What are the drug payment stages for Healthfirst CompleteCare members?</td>
<td>145</td>
</tr>
<tr>
<td>3</td>
<td>We send you reports that explain payments for your drugs and which payment stage you are in</td>
<td>146</td>
</tr>
<tr>
<td>3.1</td>
<td>We send you a monthly report called the “Part D Explanation of Benefits” (the “Part D EOB”)</td>
<td>146</td>
</tr>
<tr>
<td>3.2</td>
<td>Help us keep our information about your drug payments up to date</td>
<td>147</td>
</tr>
<tr>
<td>4</td>
<td>During the Deductible Stage, you pay the full cost of your drugs</td>
<td>148</td>
</tr>
<tr>
<td>4.1</td>
<td>You stay in the Deductible Stage until you have paid $415 for your drugs</td>
<td>148</td>
</tr>
<tr>
<td>5</td>
<td>During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share</td>
<td>149</td>
</tr>
<tr>
<td>5.1</td>
<td>A table that shows your costs for a one-month supply of a drug</td>
<td>149</td>
</tr>
<tr>
<td>5.2</td>
<td>If your doctor prescribes less than a full month’s supply, you may not have to pay the cost of the entire month’s supply</td>
<td>150</td>
</tr>
<tr>
<td>5.3</td>
<td>A table that shows your costs for a long-term (90-day) supply of a drug</td>
<td>151</td>
</tr>
<tr>
<td>5.4</td>
<td>You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,820</td>
<td>152</td>
</tr>
</tbody>
</table>
SECTION 6  During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 37% of the costs of generic drugs.......................................................... 153

Section 6.1  You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,100.......................................................... 153

Section 6.2  How Medicare calculates your out-of-pocket costs for prescription drugs.......................................................... 154

SECTION 7  During the Catastrophic Coverage Stage, the plan pays most of the costs for your drugs............................................... 156

Section 7.1  Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year........................................ 156

SECTION 8  What you pay for vaccinations covered by Part D depends on how and where you get them........................................ 156

Section 8.1  Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine........ 156

Section 8.2  You may want to call us at Member Services before you get a vaccination.......................................................... 158
Chapter 6. What you pay for your Part D prescription drugs

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the “Extra Help” program, some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you. We send you a separate insert, called the “Evidence of Coverage Rider for People Who Get “Extra Help” Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back of this booklet.)

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
  - This Drug List tells which drugs are covered for you.
  - Whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back of this booklet). You can also find the Drug List on our website at [www.HFMedicareMaterials.org](http://www.HFMedicareMaterials.org). The Drug List on the website is always the most current.

- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
• **The plan’s Provider/Pharmacy Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Provider/Pharmacy Directory has a list of pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

### Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called “cost-sharing,” and there are three ways you may be asked to pay.

- The **“deductible”** is the amount you must pay for drugs before our plan begins to pay its share.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.

- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

### SECTION 2 What you pay for a drug depends on which “drug payment stage” you are in when you get the drug

### Section 2.1 What are the drug payment stages for Healthfirst CompleteCare members?

As shown in the table below, there are “drug payment stages” for your Medicare Part D prescription drug coverage under Healthfirst CompleteCare. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.
<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
<th>Stage 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yearly Deductible Stage</strong></td>
<td><strong>Initial Coverage Stage</strong></td>
<td><strong>Coverage Gap Stage</strong></td>
<td><strong>Catastrophic Coverage Stage</strong></td>
</tr>
<tr>
<td>If you receive “Extra Help” to pay your prescription drugs, this payment stage does not apply to you. During this stage, you pay the full cost of your drugs. You stay in this stage until you have paid $415 for your drugs ($415 is the amount of your deductible). (Details are in Section 4 of this chapter.)</td>
<td>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost. You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total $3,820. (Details are in Section 5 of this chapter.)</td>
<td>During this stage, you pay 25% of the price for brand name drugs plus a portion of the dispensing fee) and 37% of the price for generic drugs. You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of $5,100. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)</td>
<td>During this stage, the plan will pay most of the costs of your drugs for the rest of the calendar year (through December 31, 2019). (Details are in Section 7 of this chapter.)</td>
</tr>
</tbody>
</table>

**SECTION 3**  
We send you reports that explain payments for your drugs and which payment stage you are in

**Section 3.1**  
We send you a monthly report called the “Part D Explanation of Benefits” (the “Part D EOB”)

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “out-of-pocket” cost.
• We keep track of your “total drug costs.” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

• **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

• **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

| Section 3.2 Help us keep our information about your drug payments up to date |

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

• **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

• **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
• **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

• **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a Part D EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

<table>
<thead>
<tr>
<th>SECTION 4</th>
<th>During the Deductible Stage, you pay the full cost of your drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 4.1</strong></td>
<td>You stay in the Deductible Stage until you have paid $415 for your drugs</td>
</tr>
</tbody>
</table>

Because most of our members get “Extra Help” with their prescription drug costs, the Deductible Stage does not apply to most members. If you receive “Extra Help,” this payment stage does not apply to you.

Look at the separate insert (the “LIS Rider”) for information about your deductible amount.

If you do **not** receive “Extra Help,” the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan’s deductible amount, which is $415 for 2019.

- Your **full cost** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **deductible** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid $415 for your drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.
During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

<table>
<thead>
<tr>
<th>Section 5.1</th>
<th>A table that shows your costs for a one-month supply of a drug</th>
</tr>
</thead>
</table>

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.
Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug from:

<table>
<thead>
<tr>
<th></th>
<th>Standard retail cost-sharing (in-network)</th>
<th>Mail-order cost-sharing</th>
<th>Long-term care (LTC) cost-sharing</th>
<th>Out-of-network cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(up to a 30-day supply)</td>
<td>(up to a 30-day supply)</td>
<td>(up to a 31-day supply)</td>
<td>(Coverage is limited to certain situations; see Chapter 5 for details.)</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
</tr>
<tr>
<td>(including brand drugs</td>
<td>$0 copay or $1.25 copay or $3.40 copay or</td>
<td>$0 copay or $1.25 copay or $3.40</td>
<td>$0 copay or $1.25 copay or $3.40</td>
<td>$0 copay or $1.25 copay or $3.40</td>
</tr>
<tr>
<td>treated as generic)</td>
<td>up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
</tr>
<tr>
<td>For all other drugs</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
<td>Depending on your “Extra Help” you pay:</td>
</tr>
<tr>
<td></td>
<td>$0 copay or $3.80 copay or $8.40 copay or</td>
<td>$0 copay or $3.80 copay or $8.40</td>
<td>$0 copay or $3.80 copay or $8.40</td>
<td>$0 copay or $3.80 copay or $8.40</td>
</tr>
<tr>
<td></td>
<td>up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
<td>copay or up to 25% of the cost</td>
</tr>
</tbody>
</table>

**Section 5.2** If your doctor prescribes less than a full month’s supply, you may not have to pay the cost of the entire month’s supply

Typically, the amount you pay for a prescription drug covers a full month’s supply of a covered drug. However your doctor can prescribe less than a month’s supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month’s supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month’s supply, you will not have to pay for the full month’s supply for certain drugs.

The amount you pay when you get less than a full month’s supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).
• If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month’s supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month’s supply, the amount you pay will be less.

• If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

  o Here’s an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days’ supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month’s supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month’s supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days’ supply you receive.

<table>
<thead>
<tr>
<th>Section 5.3</th>
<th>A table that shows your costs for a long-term (up to a 90-day) supply of a drug</th>
</tr>
</thead>
</table>

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)
The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

**Your share of the cost when you get a long-term supply of a covered Part D prescription drug:**

<table>
<thead>
<tr>
<th>Standard retail cost-sharing (in-network)</th>
<th>Mail-order cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>(up to a 90-day supply)</td>
<td></td>
</tr>
<tr>
<td><strong>Generic drugs (including brand drugs treated as generic)</strong></td>
<td></td>
</tr>
<tr>
<td>Depending on your “Extra Help” you pay:</td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td>Depending on your “Extra Help” you pay:</td>
</tr>
<tr>
<td>$1.25 copay or</td>
<td>$0 copay or</td>
</tr>
<tr>
<td>$3.40 copay or up to 25% of the cost</td>
<td>$1.25 copay or</td>
</tr>
<tr>
<td></td>
<td>$3.40 copay or up to 25% of the cost</td>
</tr>
<tr>
<td><strong>For all other drugs</strong></td>
<td></td>
</tr>
<tr>
<td>Depending on your “Extra Help” you pay:</td>
<td></td>
</tr>
<tr>
<td>$0 copay or</td>
<td>Depending on your “Extra Help” you pay:</td>
</tr>
<tr>
<td>$3.80 copay or</td>
<td>$0 copay or</td>
</tr>
<tr>
<td>$8.50 copay or up to 25% of the cost</td>
<td>$3.80 copay or</td>
</tr>
<tr>
<td></td>
<td>$8.50 copay or up to 25% of the cost</td>
</tr>
</tbody>
</table>

### Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $3,820

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,820 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5.6 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $415 you paid when you were in the Deductible Stage
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time...
during 2019, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $3,820. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $3,820 you leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

The Part D Explanation of Benefits (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the $3,820 limit in a year.

We will let you know if you reach this $3,820 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 37% of the costs of generic drugs

| Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach $5,100 |

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan 63% does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is $5,100.

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of $5,100, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.
Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

**These payments are included in your out-of-pocket costs**

*When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
  - The Coverage Gap Stage

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

**It matters who pays:**

- If you make these payments yourself, they are included in your out-of-pocket costs.

- These payments are *also included* if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of $5,100 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.
These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan’s requirements for out-of-network coverage.
- Drugs covered by Medicaid only,
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, workers compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back of this booklet).

How can you keep track of your out-of-pocket total?

- We will help you. The Part D Explanation of Benefits (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of $5,100 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.

Make sure we have the information we need. Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.
SECTION 7  
During the Catastrophic Coverage Stage, the plan pays most of the costs for your drugs

Section 7.1  
Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $5,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

If you receive “Extra Help” to pay for your prescription drugs, your costs for covered drugs will depend on the level of “Extra Help” you receive. During this stage, your share of the cost for a covered drug will be either:

- $0; or
- A coinsurance or a copayment, whichever is the larger amount:
  - either – coinsurance of 5% of the cost of the drug
  - or – $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.
  - Our plan pays the rest of the cost.

Look at the separate insert (the “LIS Rider”) for information about your costs during the Catastrophic Coverage Stage.

SECTION 8  
What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1  
Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccine. (This is sometimes called the “administration” of the vaccine.)
What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Benefits Chart (what is covered and what you pay)*.
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.

2. **Where you get the vaccine medication**.

3. **Who gives you the vaccine**?

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

*Situation 1:* You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.
Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay you back for our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay you back for our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to ask us to pay you back for our share of the cost.
CHAPTER 7

Asking us to pay our share of a bill you have received for covered medical services or drugs
Chapter 7. Asking us to pay a bill you have received for covered medical services or drugs

SECTION 1 Situations in which you should ask us to pay for your covered services or drugs ....................................................... 161

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment .................... 161

SECTION 2 How to ask us to pay you back or to pay a bill you have received ..................................................................................... 163

Section 2.1 How and where to send us your request for payment ................................................................................. 163

SECTION 3 We will consider your request for payment and say yes or no ........................................................................................... 164

Section 3.1 We check to see whether we should cover the service or drug ................................................................................. 164

Section 3.2 If we tell you that we will not pay for the medical care or drug, you can make an appeal .................... 165

SECTION 4 Other situations in which you should save your receipts and send copies to us .............................................................. 165

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs .......... 165
SECTION 1 Situations in which you should ask us to pay for your covered services or drugs

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment

Our network providers bill the plan directly for your covered services and drugs – you should not get a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

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

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid for the service, we will pay you back.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.
Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and resolve the billing problem.

If you have already paid a bill to a network provider, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan.

Sometimes a person’s enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back. You will need to submit paperwork for us to handle the reimbursement. Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back of this booklet.)

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.) Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don’t have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself. Save your receipt and send a copy to us when you ask us to pay you back.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan’s List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn’t know
about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It’s a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don’t have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.healthfirst.org/medicare) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back of this booklet.)

Mail your request for payment for medical costs together with any bills or receipts to us at this address:

Healthfirst Medicare Plan
Claims Department
P.O. Box 5165
New York, NY 10274-5165

Mail your request for payment for drug costs together with all original receipts to us at this address:

Paper Claims Department – RxClaim
CVS Caremark
P.O. Box 52066
Phoenix, AZ 85072-2066
Your original pharmacy receipts must include:
• Patient Name
• Prescription Number
• Medicine NDC number
• Date of Fill
• Metric Quantity
• Total Charge
• Days Supply for your prescription (you may need to ask your pharmacist for this “Days Supply” information)
• Pharmacy Name and Address or Pharmacy NABP Number

Contact Member Services if you have any questions (phone numbers are printed on the back of this booklet). If you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3  We will consider your request for payment and say yes or no

| Section 3.1 | We check to see whether we should cover the service or drug |

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for the service. If you have already paid for the service or drug, we will mail your reimbursement to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)

- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.
Section 3.2  If we tell you that we will not pay for the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don’t agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

SECTION 4  Other situations in which you should save your receipts and send copies to us

Section 4.1  In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a
program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan’s benefits, we will not pay for these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.
CHAPTER 8

Your rights and responsibilities
Chapter 8. Your rights and responsibilities

SECTION 1  Our plan must honor your rights as a member of the plan ... 169

Section 1.1  We must provide information in a way that works for you (in languages other than English, in Braille, large print, or other alternate formats, etc.) ................................................................. 169

Section 1.2  We must treat you with fairness and respect at all times .......... 170

Section 1.3  We must ensure that you get timely access to your covered services and drugs................................................................. 171

Section 1.4  We must protect the privacy of your personal health information 171

Section 1.5  We must give you information about the plan, its network of providers, and your covered services........................................ 172

Section 1.6  We must support your right to make decisions about your care .. 174

Section 1.7  You have the right to make complaints and to ask us to reconsider decisions we have made ........................................... 176

Section 1.8  What can you do if you believe you are being treated unfairly or your rights are not being respected? ................................. 177

Section 1.9  How to get more information about your rights ................... 177

SECTION 2  You have some responsibilities as a member of the plan..... 178

Section 2.1  What are your responsibilities? ............................................. 178
SECTION 1  Our plan must honor your rights as a member of the plan

Section 1.1  We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan’s benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back of this booklet) or contact the Civil Rights Bureau at 212-416-8250.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services at 1-888-260-1010, TTY 1-888-542-3821). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact 1-888-260-1010, TTY 1-888-542-3821 for more for additional information.

Para recibir información de nosotros de una manera conveniente y efectiva, llame por favor a Servicios a los Miembros (los números telefónicos están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personal capacitado y servicios gratuitos de interpretación de idiomas disponibles para responder las preguntas de los miembros discapacitados y que no hablan inglés. También podemos brindarle información en formato Braille, en letra grande o en otros formatos alternativos, sin ningún costo, si lo necesita. Se nos exige que le brindemos información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información de nuestra parte de la manera que le resulte más conveniente, por favor, llame a Servicios a los Miembros (los números de teléfono aparecen en la contraportada de este folleto) o comuníquese con el Departamento de Derechos Civiles (Civil Rights Bureau) al 212-416-8250.

Si tiene problemas para obtener información de parte de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame al Plan Cuidado 1-888-260-1010, TTY 1-888-867-4132 para presentar una queja formal. También puede presentar una queja con Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o
Section 1.2 We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person’s race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

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 us at Member Services (phone numbers are printed on the back of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.
Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back of this booklet). We do not require you to get referrals to go to network providers.

As a plan member, you have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don’t agree with our decision, Chapter 9, Section 5 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.

- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
For example, we are required to release health information to government agencies that are checking on quality of care.

Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back of this booklet).

<table>
<thead>
<tr>
<th>Section 1.5</th>
<th>We must give you information about the plan, its network of providers, and your covered services</th>
</tr>
</thead>
</table>

As a member of Healthfirst CompleteCare, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back of this booklet):

- **Information about our plan.** This includes, for example, information about the plan’s financial condition. It also includes information about the number of appeals made by members and the plan’s performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
• **Information about our network providers including our network pharmacies.**
  
  o For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  
  o For a list of the providers and pharmacies in the plan’s network, see the Healthfirst CompleteCare Provider/Pharmacy Directory.
  
  o For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back of this booklet) or visit our website at www.HFMedicareMaterials.org.
  
• **Information about your coverage and the rules you must follow when using your coverage.**
  
  o In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  
  o To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan’s List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  
  o If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back of this booklet).
  
• **Information about why something is not covered and what you can do about it.**
  
  o If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  
  o If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  
  o If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.
Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

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

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.
You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “healthcare proxy form,” and “power of attorney for health care” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back of this booklet).
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.
What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with The New York State Department of Health:

The New York State Department of Health
Bureau of Managed Care Certification and Surveillance
Managed Care Complaint Unit
OHIP DHPCO 1CP–1609
Albany, New York 12237-0062
1-800-206-8125
managedcarecomplaint@health.ny.gov

At Healthfirst, we are required to comply with the New York State Law on Advanced Directives. Our staff is educated on these policies and procedures, and provides education for the community as well. We will maintain your Advance Directive information in a prominent part of our records for you.

If you have signed an Advance Directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with The New York State Department of Health.

Just because you tell someone your wishes does not mean they will be followed. By law, you must write them down, sign the form, and have an adult witness it.

You can change your mind about your health care proxy or advance directives at any time. Just fill out new forms, sign them, and have them witnessed.

| Section 1.7 | You have the right to make complaints and to ask us to reconsider decisions we have made |

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back of this booklet).
Section 1.8 What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, (including gender identity or status of being transgender), health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services’ Office for Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it’s not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services (phone numbers are printed on the back of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Member Services (phone numbers are printed on the back of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare.
  - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: https://www.medicare.gov/sites/default/files/2018-07/11534-medicare-rights-and-protections.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back of this booklet). We’re here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know (phone numbers are printed on the back of this booklet).
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “coordination of benefits” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 8.1.)

- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card and your Medicaid card whenever you get your medical care or Part D prescription drugs.

- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For most Healthfirst CompleteCare members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
  
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  
  - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must pay the extra amount directly to the government to remain a member of the plan.

- **Tell us if you move.** If you are going to move, it’s important to tell us right away. Call Member Services (phone numbers are printed on the back of this booklet).
  
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
  
  - If you move within our service area, we still need to know so we can keep your membership record up to date and know how to contact you.
  
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.**
  
  - Phone numbers and calling hours for Member Services are printed on the back of this booklet.
  
  - For more information on how to reach us, including our mailing address, please see Chapter 2.
CHAPTER 9

What to do if you have a problem or complaint (coverage decisions, appeals, complaints)
## Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

### BACKGROUND

<table>
<thead>
<tr>
<th>SECTION 1</th>
<th>Introduction</th>
<th>186</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1.1</td>
<td>What to do if you have a problem or concern</td>
<td>186</td>
</tr>
<tr>
<td>Section 1.2</td>
<td>What about the legal terms?</td>
<td>186</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 2</th>
<th>You can get help from government organizations that are not connected with us</th>
<th>187</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2.1</td>
<td>Where to get more information and personalized assistance</td>
<td>187</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 3</th>
<th>To deal with your problem, which process should you use?</th>
<th>188</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 3.1</td>
<td>Should you use the process for Medicare benefits or Medicaid benefits?</td>
<td>188</td>
</tr>
</tbody>
</table>

### PROBLEMS ABOUT YOUR MEDICARE BENEFITS

<table>
<thead>
<tr>
<th>SECTION 4</th>
<th>Handling problems about your Medicare benefits</th>
<th>189</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 4.1</td>
<td>Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</td>
<td>189</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 5</th>
<th>A guide to the basics of coverage decisions and appeals</th>
<th>190</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 5.1</td>
<td>Asking for coverage decisions and making appeals: the big picture</td>
<td>190</td>
</tr>
<tr>
<td>Section 5.2</td>
<td>How to get help when you are asking for a coverage decision or making an appeal</td>
<td>191</td>
</tr>
<tr>
<td>Section 5.3</td>
<td>Which section of this chapter gives the details for your situation?</td>
<td>192</td>
</tr>
<tr>
<td>SECTION 6</td>
<td>Your medical care: How to ask for a coverage decision or make an appeal</td>
<td>192</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Section 6.1</td>
<td>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care</td>
<td>192</td>
</tr>
<tr>
<td>Section 6.2</td>
<td>Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)</td>
<td>194</td>
</tr>
<tr>
<td>Section 6.3</td>
<td>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)</td>
<td>197</td>
</tr>
<tr>
<td>Section 6.4</td>
<td>Step-by-step: How a Level 2 Appeal is done</td>
<td>201</td>
</tr>
<tr>
<td>Section 6.5</td>
<td>What if you are asking us to pay you back for a bill you have received for medical care?</td>
<td>202</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION 7</th>
<th>Your Part D prescription drugs: How to ask for a coverage decision or make an appeal</th>
<th>204</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 7.1</td>
<td>This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug</td>
<td>204</td>
</tr>
<tr>
<td>Section 7.2</td>
<td>What is an exception?</td>
<td>206</td>
</tr>
<tr>
<td>Section 7.3</td>
<td>Important things to know about asking for exceptions</td>
<td>206</td>
</tr>
<tr>
<td>Section 7.4</td>
<td>Step-by-step: How to ask for a coverage decision, including an exception</td>
<td>207</td>
</tr>
<tr>
<td>Section 7.5</td>
<td>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</td>
<td>210</td>
</tr>
<tr>
<td>Section 7.6</td>
<td>Step-by-step: How to make a Level 2 Appeal</td>
<td>213</td>
</tr>
<tr>
<td>SECTION 8</td>
<td>How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon .......... 215</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Section 8.1</td>
<td>During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights ................................................................. 216</td>
<td></td>
</tr>
<tr>
<td>Section 8.2</td>
<td>Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date ................................................................. 217</td>
<td></td>
</tr>
<tr>
<td>Section 8.3</td>
<td>Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date ................................................................. 220</td>
<td></td>
</tr>
<tr>
<td>Section 8.4</td>
<td>What if you miss the deadline for making your Level 1 Appeal? ...................................................................... 221</td>
<td></td>
</tr>
<tr>
<td>SECTION 9</td>
<td>How to ask us to keep covering certain medical services if you think your coverage is ending too soon ................. 224</td>
<td></td>
</tr>
<tr>
<td>Section 9.1</td>
<td>This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services ................................................................. 224</td>
<td></td>
</tr>
<tr>
<td>Section 9.2</td>
<td>We will tell you in advance when your coverage will be ending ................................................................... 225</td>
<td></td>
</tr>
<tr>
<td>Section 9.3</td>
<td>Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time ................................................................. 226</td>
<td></td>
</tr>
<tr>
<td>Section 9.4</td>
<td>Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time ................................................................. 228</td>
<td></td>
</tr>
<tr>
<td>Section 9.5</td>
<td>What if you miss the deadline for making your Level 1 Appeal? ...................................................................... 229</td>
<td></td>
</tr>
<tr>
<td>SECTION 10</td>
<td>Taking your appeal to Level 3 and beyond .................................................................................................. 232</td>
<td></td>
</tr>
<tr>
<td>Section 10.1</td>
<td>Levels of Appeal 3, 4, and 5 for Medical Service Appeals ................................................................. 232</td>
<td></td>
</tr>
<tr>
<td>Section 10.2</td>
<td>Levels of Appeal 3, 4, and 5 for Part D Drug Appeals .................................................................................. 234</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns ......................... 235

Section 11.1 What kinds of problems are handled by the complaint process? 235

Section 11.2 The formal name for “making a complaint” is “filing a grievance” 237

Section 11.3 Step-by-step: Making a complaint .......................................................... 237

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization .................................................. 238

Section 11.5 You can also tell Medicare about your complaint ............................. 239

PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12 Handling problems about your Medicaid benefits .................. 240
BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by Medicare or Medicaid. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services (phone numbers are printed on the back of this booklet).

2. The type of problem you are having:
   - For some types of problems, you need to use the process for coverage decisions and appeals.
   - For other types of problems, you need to use the process for making complaints.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” “or at-risk determination” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.
However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program (SHIP). This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (https://www.medicare.gov).

You can get help and information from Medicaid

For questions or assistance, contact New York State Medicaid. To get information from Medicaid, you can call the New York State Department of Health Medicaid Program at 1-800-505-5678, TTY 1-888-329-1541.
## SECTION 3  
To deal with your problem, which process should you use?

### Section 3.1 Should you use the process for Medicare benefits or Medicaid benefits?

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services (phone numbers are printed on the back of this booklet).

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

<table>
<thead>
<tr>
<th>Is your problem about Medicare benefits or Medicaid benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services. Phone numbers for Member Services are printed on the back of this booklet.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My problem is about Medicare benefits.</th>
<th>My problem is about Medicaid coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go to the next section of this chapter, Section 4, “Handling problems about your Medicare benefits.”</td>
<td>Skip ahead to Section 12 of this chapter, “Handling problems about your Medicaid benefits.”</td>
</tr>
</tbody>
</table>
# PROBLEMS ABOUT YOUR MEDICARE BENEFITS

## SECTION 4 Handling problems about your Medicare benefits

<table>
<thead>
<tr>
<th>Section 4.1</th>
<th>Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</th>
</tr>
</thead>
</table>

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about benefits covered by Medicare.

To figure out which part of this chapter will help with your problem or concern about your Medicare benefits, use this chart:

<table>
<thead>
<tr>
<th>Is your problem or concern about your benefits or coverage?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes. My problem is about benefits or coverage.</th>
<th>No. My problem is not about benefits or coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Go on to the next section of this chapter, Section 5, “A guide to the basics of coverage decisions and appeals.”</td>
<td>Skip ahead to Section 11 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”</td>
</tr>
</tbody>
</table>
SECTION 5 A guide to the basics of coverage decisions and appeals

Section 5.1 Asking for coverage decisions and making appeals: the big picture

The process for asking for coverage decisions and appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent
organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

### Section 5.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are printed on the back of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare’s website at [https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal assistance.
services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

<table>
<thead>
<tr>
<th>Section 5.3</th>
<th>Which section of this chapter gives the details for your situation?</th>
</tr>
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</table>

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 6 Your medical care: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

<table>
<thead>
<tr>
<th>Section 6.1</th>
<th>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care</th>
</tr>
</thead>
</table>

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical
This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:

  o Chapter 9, Section 8: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*

  o Chapter 9, Section 9: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.
## Which of these situations are you in?

<table>
<thead>
<tr>
<th>If you are in this situation:</th>
<th>This is what you can do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to find out whether we will cover the medical care or services you want?</td>
<td>You can ask us to make a coverage decision for you.</td>
</tr>
<tr>
<td></td>
<td>Go to the next section of this chapter, Section 6.2.</td>
</tr>
<tr>
<td>Have we already told you that we will not cover or pay for a medical service in the way that</td>
<td>You can make an appeal. (This means you are asking us to reconsider.)</td>
</tr>
<tr>
<td>you want it to be covered or paid for?</td>
<td>Skip ahead to Section 6.3 of this chapter.</td>
</tr>
<tr>
<td>Do you want to ask us to pay you back for medical care or services you have already received</td>
<td>You can send us the bill.</td>
</tr>
<tr>
<td>and paid for?</td>
<td>Skip ahead to Section 6.5 of this chapter.</td>
</tr>
</tbody>
</table>

### Section 6.2  Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

#### Legal Terms

- **When a coverage decision involves your medical care, it is called an “organization determination.”**

**Step 1:** You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

#### Legal Terms

- A “fast coverage decision” is called an “expedited determination.”

**How to request coverage for the medical care you want**

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*
Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request.

- However, 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.

- 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. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- A fast coverage decision means we will answer within 72 hours.
  - However, 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.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.

- To get a fast coverage decision, you must meet two requirements:
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.
If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.

- If we decide that your medical condition does not meet the requirements for a fast coverage decision, 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 doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

**Step 2: We consider your request for medical care coverage and give you our answer.**

**Deadlines for a “fast” coverage decision**

- Generally, for a fast coverage decision, we will give you our answer within 72 hours.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - 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 have the right to appeal. Section 6.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.
Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

197

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer within 14 calendar days of receiving your request.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try 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 Section 6.3 below).

Section 6.3 Step-by-step: How to make a Level 1 Appeal
(How to ask for a review of a medical care coverage decision made by our plan)

<table>
<thead>
<tr>
<th>Legal Terms</th>
<th>An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”</th>
</tr>
</thead>
</table>
Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- To start an appeal you, your doctor, or your representative, must contact us. For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are making an appeal about your medical care.

- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).
  
    o If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.
  
    o You have the right to ask us for a copy of the information regarding your appeal.
If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us).

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

The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)

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

Step 2: We consider your appeal and we give you our answer.

When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so.

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 to take extra days to make the decision, we will tell you in writing.

If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
• If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

• If our answer is no to part of all of what your requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

• Deadlines for a “standard” appeal

• If we are using the standard deadlines, we must give you our answer within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  o 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 to take extra days to make the decision, we will tell you in writing.
  o If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  o If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, 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 requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.

• If our answer is no to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

• To make sure we were following all the rules when we said no to your appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.
Section 6.4  Step-by-step: How a Level 2 Appeal is done

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 Independent Review Organization reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

| Legal Terms | The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.” |

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees 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 copy of your case file.**

- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

*If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2*

- If you had a fast appeal to our plan at Level 1, you will automatically receive 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 receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, it **can take up to 14 more calendar days.**

*If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2*

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, it **can take up to 14 more calendar days.**
Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.

- If this organization 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.” It is also called “turning down your appeal.”)
  - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

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

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.

- The Level 3 Appeal is handled by Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.5 What if you are asking us to pay you back for a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.
Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: Benefits Chart (what is covered). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: Using the plan’s coverage for your medical and other covered services).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your request. Or, if you haven’t paid for the services, we will send the payment directly to the provider. When we send the payment, it’s the same as saying yes to your request for a coverage decision.

- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it’s the same as saying no to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.
SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)?
If not, you may want to read it before you start this section.

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s List of Covered Drugs (Formulary). To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- This section is about your Part D drugs only. To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.

- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 (Using our plan’s coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is called a “coverage determination.”

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
• You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
  
  o Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

• You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

<table>
<thead>
<tr>
<th>If you are in this situation:</th>
<th>This is what you can do:</th>
</tr>
</thead>
</table>
| Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover? | You can ask us to make an exception. (This is a type of coverage decision.)
Start with Section 7.2 of this chapter. |
| Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? | You can ask us for a coverage decision.
Skip ahead to Section 7.4 of this chapter. |
| Do you want to ask us to pay you back for a drug you have already received and paid for? | You can ask us to pay you back. (This is a type of coverage decision.)
Skip ahead to Section 7.4 of this chapter. |
| Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? | You can make an appeal. (This means you are asking us to reconsider.)
Skip ahead to Section 7.5 of this chapter. |
**Section 7.2 What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** (We call it the “Drug List” for short.)

   - The extra rules and restrictions on coverage for certain drugs include:
     - **Being required to use the generic version** of a drug instead of the brand name drug.
     - **Getting plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
     - **Being required to try a different drug first** before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
     - **Quantity limits.** For some drugs, there are restrictions on the amount of the drug you can have.

2. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 3).

   - Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”

**Section 7.3 Important things to know about asking for exceptions**

**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.
Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

<table>
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<tr>
<th>Section 7.4</th>
<th>Step-by-step: How to ask for a coverage decision, including an exception</th>
</tr>
</thead>
</table>

**Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a “fast coverage decision.” You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

**What to do**

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs.* Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received.*

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells
how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

**If your health requires it, ask us to give you a “fast coverage decision”**

<table>
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<tr>
<th>Legal</th>
<th>A “fast coverage decision” is called an expedited coverage determination.</th>
</tr>
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</table>

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision **only** if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision **only** if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, 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 doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer within 24 hours.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.

- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested** –
  - If we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor’s statement supporting your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Deadlines for a “standard” coverage decision about payment for a drug you have already bought**

- We must give you our answer within 14 calendar days after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

<table>
<thead>
<tr>
<th>Section 7.5</th>
<th>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Terms</td>
<td>An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”</td>
</tr>
</tbody>
</table>
Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.
  
  o For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, How to contact us when you are making an appeal about your Part D prescription drugs.

- If you are asking for a standard appeal, make your appeal by submitting a written request. You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (How to contact our plan when you are making an appeal about your Part D prescription drugs).

- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1 (How to contact our plan when you are making an appeal about your part D prescription drugs).

- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- You can ask for a copy of the information in your appeal and add more information.
  
  o You have the right to ask us for a copy of the information regarding your appeal.
  
  o If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.
If your health requires it, ask for a “fast appeal”

Legal Terms

A “fast appeal” is also called an “expedited redetermination.”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 7.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, 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 requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this
section, we tell 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 requested** –
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

**Step 3:** If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
  - If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

### Section 7.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

| Legal Terms | The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.” |

**Step 1:** To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**

You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

**Deadlines for “fast” appeal at Level 2**

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”

- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

**Deadlines for “standard” appeal at Level 2**

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.

- **If the Independent Review Organization says yes to part or all of what you requested** –
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by Administrative Law Judge or attorney adjudicator. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: Benefits Chart (what is covered).
During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

### Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
   - Where to report any concerns you have about quality of your hospital care.
   - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

### Legal Terms

The written notice from Medicare tells you how you can "**request an immediate review.**" Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)
2. **You must sign the written notice to show that you received it and understand your rights.**

   - You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice *does not mean* you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

   - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html).

### Section 8.2  Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.
Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

A “fast review” is also called an “immediate review.”

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (An Important Message from Medicare About Your Rights) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  
  o If you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  
  o If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a “fast review” of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

| Legal | A “fast review” is also called an “immediate review.” |
| Terms |     |
Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

This written explanation is called the “Detailed Notice of Discharge.” You can get a sample of this notice by calling Member Services (phone numbers are printed on the back of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day
after the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4:** If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

### Section 8.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

**Step 1:** You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review within 60 calendar days after the day the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

**Step 2:** The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.
Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

| Legal Terms | A “fast” review (or “fast appeal”) is also called an “expedited appeal”. |

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are making an appeal about your medical care.
- Be sure to ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.
Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

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, an Independent Review Organization reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms

| The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.” |

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are
coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
  
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

**Step 3:** If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

### SECTION 9

**How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

**Section 9.1**  
This section is about three services only:  
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care only:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, Definitions of important words.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, Definitions of important words.)
When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

### Section 9.2 We will tell you in advance when your coverage will be ending

**1. You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.

- The written notice tells you the date when we will stop covering the care for you.
- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

#### Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)

The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services (phone numbers are printed on the back of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at [https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html](https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html).
2. You must sign the written notice to show that you received it.
   - You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

| Section 9.3 | Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time |

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**

**Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.**

**What is the Quality Improvement Organization?**
- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it’s time to stop covering certain kinds of medical care.
How can you contact this organization?
- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?
- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.
- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?
- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal
This notice explanation is called the Terms
“Detailed Explanation of Non-Coverage.”

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?
- If the reviewers say yes to your appeal, then we must keep providing your covered services for as long as it is medically necessary.
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then your coverage will end on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then you will have to pay the full cost of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say no to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 9.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review within 60 days after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.
Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 9.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make
your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal
A “fast” review (or “fast appeal”) is also called an “expedited appeal”.

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are making an appeal about your medical care.
- Be sure to ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- If we say yes to your fast appeal, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- If we say no to your fast appeal, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the
date when we said your coverage would end, then you will have to pay the full cost of this care yourself.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, we are required to send your appeal to the “Independent Review Organization.” When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

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 **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.  

| Legal Terms | The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.” |

**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the
date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

**Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
  - Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**SECTION 10  Taking your appeal to Level 3 and beyond**

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<th>Section 10.1</th>
<th>Levels of Appeal 3, 4, and 5 for Medical Service Appeals</th>
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.
Level 3 Appeal  A judge (called and Administrative Law Judge) or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge or attorney adjudicator decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal  The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.

- If the answer is no or if the Council denies the review request, the appeals process may or may not be over.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal**
A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

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### Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal**
A judge (called an Administrative Law Judge) or attorney adjudicator who works for the Federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Administrative Law Judge or attorney adjudicator within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.
Level 4 Appeal  The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal  A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process.

SECTION 11  How to make a complaint about quality of care, waiting times, customer service, or other concerns

- If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

Section 11.1  What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.
If you have any of these kinds of problems, you can “make a complaint”

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of your medical care</td>
<td>• Are you unhappy with the quality of the care you have received (including care in the hospital)?</td>
</tr>
<tr>
<td>Respecting your privacy</td>
<td>• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?</td>
</tr>
</tbody>
</table>
| Disrespect, poor customer service, or other negative behaviors | • Has someone been rude or disrespectful to you?  
• Are you unhappy with how our Member Services has treated you?  
• Do you feel you are being encouraged to leave the plan?                                                                                                                                                                                                                   |
| Waiting times                                           | • Are you having trouble getting an appointment, or waiting too long to get it?  
• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?  
  o Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.                                                                                                                                                        |
| Cleanliness                                             | • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?                                                                                                                                                                                                                                          |
| Information you get from us                            | • Do you believe we have not given you a notice that we are required to give?  
• Do you think written information we have given you is hard to understand?                                                                                                                                                                                                                                                        |
| Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals) | The process of asking for a coverage decision and making appeals is explained in Sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.  
However, if you have already asked us for a coverage decision 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:  
  • If you have asked us to give you a “fast coverage decision” or a “fast appeal, and we have said we will not, you can make a complaint.  
  • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.  
  • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.  
  • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint. |


Section 11.2  The formal name for “making a complaint” is “filing a grievance”

Legal Terms
- What this section calls a “complaint” is also called a “grievance.”
- Another term for “making a complaint” is “filing a grievance.”
- Another way to say “using the process for complaints” is “using the process for filing a grievance.”

Section 11.3  Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. The phone number for Member Services is 1-888-260-1010 (TTY users should call 1-888-542-3821), 7 days a week from 8am to 8pm.

- **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.

- **Send your complaint to us in writing using the address listed in Chapter 2, Section 1 called How to contact us when you are making a complaint about your medical care.**

- **Your letter needs to be dated no more than 60 calendar days after the date of the event or incident you are writing to us about.** We will answer your complaint either in writing or by telephone (or both) no more than 30 calendar days after the day we receive your letter. If you ask us to, or if we need more than 30 calendar days to respond to your complaint, we may take another 14 calendar days to answer. If this happens, we will call to let you know and send you a letter.

- **Your complaint may be about the amount of time we take to make a coverage determination or organization determination (also called coverage decisions); for example, we extended the timeframe for reaching a coverage decision or we denied your request to grant an expedited (fast) coverage decision.** For these types of issues, you can file an expedited (fast) complaint. We will respond by phone within 24 hours of receiving your complaint with a written explanation of our complaint resolution to follow within 3 calendar days.
- If you are not happy with how we answered your complaint, or if we disagree with your complaint, we will notify you of our answer and tell you your options for filing a level 2 complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- If you are making a complaint because we denied your request for a “fast coverage decision” 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.

| Legal Terms | What this section calls a “fast complaint” is also called an “expedited grievance.” |

**Step 2: We look into your complaint and give you our answer.**

- **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.

- **Most complaints are answered in 30 calendar days.** 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.

- **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.

**Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization**

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

### Section 11.5 You can also tell Medicare about your complaint

You can submit a complaint about Healthfirst CompleteCare directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.
PROBLEMS ABOUT YOUR MEDICAID BENEFITS

SECTION 12  Handling problems about your Medicaid benefits

Service Authorizations and Actions

When Healthfirst CompleteCare (HMO SNP) determines that services are covered solely by Medicaid, we will make decisions about your care following these rules:

Prior Authorization

Some covered services require prior authorization (approval in advance) from the Medical Management Department before you receive them or in order to be able to continue receiving them. You or someone you trust can ask for this. 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)
- Dental Services
- Private Duty Nursing

When you ask for approval of a treatment or service, it is called a service authorization request. To get a service authorization request you or your doctor may call Healthfirst Medical Management at 1-888-394-4327 or send your request in writing to:
Services will be authorized in a certain amount and for a specific period of time. This is called an **authorization period**.

You will also need to get prior authorization if you are getting one of these services now, but need to get more of the care during an authorization period. This is called **concurrent review**.

**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 requested. These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a clinical peer reviewer, who may be a doctor, a nurse or a health care professional who typically provides the care you requested. You can request the specific medical standards, called **clinical review criteria**, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a **standard** or **fast track process**. You or your doctor can ask for a fast track review if it is believed that a delay will cause serious harm to your health. If your request for a fast track review is denied, we will tell you and your request will be handled 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.

We will tell you and your provider both by phone and in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options for appeals or fair hearings you will have if you don’t agree with our decision.

**Timeframes for prior authorization requests**

- **Standard review**: We will make a decision about your request within 3 work days of when we have all the information we need, but you will hear from us no later than 14 days after we receive your request. We will tell you by the 14th day if we need more information.
• Fast track review: We will make a decision and you will hear from us within 72 hours. We will tell you within 72 hours if we need more information.

**Timeframes for concurrent review requests**

• Standard review: We will make a decision within 1 work day of when we have all the information we need, but you will hear from us no later than 14 days after we received your request.

• Fast track review: We will make a decision within 1 work day of when we have all the information we need. You will hear from us within 72 hours after we receive your request. We will tell you within 1 work day if we need more information.

If we need more information to make either a standard or fast track decision about your service request, the timeframes above can be extended up to 14 days. We will:

• Write and tell you what information is needed. If your request is in a fast track review, we will call you right away and send a written notice later.

• Tell you why the delay is in your best interest.

• 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.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-888-260-1010 (TTY: 1-888-542-3821) or writing.

You or someone you trust can file a complaint with the plan if you don’t agree with our decision to take more time to review your request. 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.

If you are not satisfied with our answer, you have the right to file an appeal with us. See the Appeal section later in this handbook.
If for some reason 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 request a State Fair Hearing. See the Fair Hearing section later in this handbook.

Other Decisions About Your Care

Sometimes we will do a concurrent review on the care you are receiving to see if you still need the care. We may also review other treatments and services you have already received. This is called retrospective review. We will tell you if we take these other actions.

Timeframes for notice of other actions

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved and you are now getting, we must tell you at least 10 days before we change the service.
- If we are checking care that has been given in the past, we will make a decision about paying for it within 30 days of receiving 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 the payment is denied. You will not have to pay for any care you received that was covered by the plan or by Medicaid even if we later deny payment to the provider.

WHAT TO DO IF YOU HAVE A COMPLAINT ABOUT OUR PLAN OR WANT TO APPEAL A DECISION ABOUT YOUR CARE

As a Dually-Eligible member of our plan, the way you make complaints and appeals about your services will depend on whether Healthfirst CompleteCare (HMO SNP) determines that the services are covered by Medicare or Medicaid.

- For complaints and appeals about a service that is covered only by Medicare (e.g. chiropractic services), you will follow the rules outlined in Chapter 9 of your Healthfirst CompleteCare (HMO SNP)'s Medicare Evidence of Coverage.
- For complaints and appeals about a service that is covered only by Medicaid (e.g. personal care services, private duty nursing, non-emergency transportation, dental services, etc.), you will follow the Medicaid rules listed below.
- For complaints and appeals about all other services covered by Healthfirst CompleteCare (HMO SNP) you may choose to follow either the Medicare rules outlined in Chapter 9 of your Healthfirst CompleteCare (HMO SNP) Evidence of Coverage or the Medicaid rules described below. If you choose to follow the Medicare rules, you cannot use your Medicaid complaint and appeal rights, including the right to a state Fair Hearing regarding the complaint or appeal. But if you choose to follow the Medicaid rules, you will have up to 60 days from the day of Healthfirst CompleteCare (HMO SNP) notice of denial of coverage to use your...
Medicare complaint and appeal rights.

Healthfirst CompleteCare (HMO SNP) will explain the complaints and appeals processes available to you depending on the complaint you have. 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.

MEDICAID RULES FOR APPEALS AND COMPLAINTS

Plan Appeals

There are some treatments and services that you need to get approval before you receive them or in order to be able to continue receiving them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. The notice of our decision to deny a service authorization request or to approve it for an amount that is less than requested is called an Initial Adverse Determination.

If you are not satisfied with our decisions about your Medicaid care, there are steps you can take.

Your provider can ask for reconsideration:

If we made a decision about your service authorization request without talking to your doctor, your doctor may ask to speak with the plan’s Medical Director. The Medical Director will talk to your doctor within one workday.

You can file a Plan Appeal:

- If you are not satisfied with our decision about your service authorization request, you have 60 days after hearing from us to file a Plan appeal.
- You can do this yourself or ask someone you trust to file the Plan appeal for you. You can call Member Services 1-888-260-1010 (TTY: 1-888-542-3821) if you need help filing a Plan appeal.
- We will not treat you any differently or act badly toward you because you file a Plan appeal.
- The Plan appeal can be made by phone or in writing. If you make an appeal by phone, unless it is fast tracked, you must also send your Plan appeal to us in writing.
Your Plan Appeal will be reviewed under the fast track process:

- If you or your doctor asks to have your Plan appeal reviewed under the fast track process. Your doctor would have to explain how a delay will cause harm to your health. If your request for fast track is denied, we will tell you and your appeal will be reviewed under the standard process; or
- If your request was denied when you asked to continue receiving care that you are now getting or need to extend a service that has been provided.
- Fast track Plan appeals can be made by phone and do not have to be followed up in writing.

Aid to Continue while appealing a decision about your care

If we decide to reduce, suspend or stop services you are getting now, you may be able to continue receiving the services while you wait for your appeal to be decided. You must ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

If we deny your appeal and you are not satisfied, you can appeal further using the External Appeals process or Fair Hearing process described below.

What happens after we get your Plan Appeal

- Within 15 days, we will send you a letter to let you know we are work on your Plan appeal. We will let you know if we need additional information to make our decision.
- We will send you a case file free of charge which includes copy of the medical records and any other information and records we will use to make the appeal decision. If your Plan Appeal is fast tracked, there may be a short time to review this information.
- Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision, at least one of whom 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 Plan at 1-888-260-1010 (TTY: 1-888-542-3821) if you are not
sure what information to give us.

- You will be given the reasons for our decision and our clinical rationale, if it applies. The notice of the Plan Appeal decision to deny your request or to approve it for an amount that is less than requested is called a **Final Adverse Determination**.

- **If you think our Final Adverse Determination is wrong:**
  - You can ask for a Fair Hearing. See Fair Hearing section of this handbook
  - For some decisions, you may be able to ask for an External Appeal. See the External Appeal section of this handbook.
  - You or someone you trust can file a complaint with the New York State Department of Health at 1-866-712-7197,

### Timeframes for Plan Appeals

- **Standard appeals:** If we have all the information we need, we will tell you our decision in **30 days** from when you asked for your Plan Appeal. A written notice of our decision will be sent within 2 work days from when we make the decision.

- **Fast track appeals:** If we have all the information we need, fast track Plan Appeal decisions will be made in 2 work days from your Plan Appeal but not more than 72 hours from when you asked for your Plan Appeal.
  - We will tell you within 72 hours if we need more information.
  - We will tell you our decision by phone and send a written notice later.

If we do not have the information we need to make either a standard or fast track decision about your Plan Appeal within the above timeframes we will:

- Write to tell you that we need more time to collect the information. If your request is in a fast track review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest;
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give the plan to help decide your case. This can be done by calling 1-888-260-1010 (TTY: 1-888-542-3821) or writing.

You or someone you trust can file a complaint with the plan if you don’t agree with our decision to take more time to review your action appeal. 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.
If you do not receive a response to your Plan Appeal or we do not decide in time, including extensions, you can ask for a Fair Hearing. See Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service was not medically necessary, was experimental or investigational, 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, the original denial will be reversed. This means your service authorization request will be approved.

External Appeals

If the plan decides to deny coverage for a medical service you and your doctor asked for because it is not medically necessary or because it is experimental or investigational, 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, you can ask New York State for an independent external appeal. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. 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:

1. You must file an Plan Appeal with the plan and get the plan’s Final Adverse Determination; or
2. If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time. Your doctor will have to say an expedited Appeal is necessary; or
3. You and the plan may agree to skip the plan’s appeals process and go directly to External Appeal; or
4. You can prove the plan did not follow the rules correctly when processing your Plan Appeal.

You have 4 months after you receive 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)

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and the plan will be told the final decision within two days after the decision is made.

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, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing, and External Appeal or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

**Fair Hearings**

**You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will then have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.**

You may ask for a Fair Hearing from New York State if:

- You are not happy with a decision your local department of social services or the State Department of Health made about your staying or leaving the Medicaid Advantage Plus Program.

- You are not happy with a decision that your doctor would not order one of the services listed above that you wanted. You feel that the doctor’s decision stops or limits your Medicaid benefits. You must file a complaint and an appeal with Healthfirst CompleteCare (HMO SNP). If Healthfirst CompleteCare (HMO SNP) agrees with your doctor, you may ask for a State Fair Hearing.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.
• You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits. You are not happy we decided to:
  • reduce, suspend or stop care you were getting; or
  • deny care you wanted; or
  • deny payment for care you received

If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you are getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a Fair Hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.

However, if you choose to ask for services to be continued, and lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

The decision you receive from the Fair Hearing will be final.

If you filed a complaint or appeal under Medicare rules, you may not then request a state Fair Hearing about the same complaint or appeal.

You can use one of the following ways to request a Fair Hearing:

• By phone. Call toll free 1-800-342-3334
• By fax at 518-473-6735
• By Internet at www.otda.state.ny.us/oah/forms.asp
• By mail:
  NYS Office of Temporary and Disability Assistance Office of Administrative Hearings
  Managed Care Hearing Unit
  P.O. Box 122023
  Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision Healthfirst CompleteCare (HMO SNP) made, we must send you a copy of the evidence packet. This information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before the hearing, you can call 1-888-260-1010 (TTY: 1- 888-542-3821) to ask for it.
Remember, you can file a complaint anytime to the New York State Department of Health by calling 1-866-712-7197. Call Member Services at 1-888-260-1010 (TTY: 1-888-542-3821) if you have any questions.

**Complaints**

We hope our plan serves you well. If you have a problem with the care or treatment you receive from our staff or providers or you do not like the quality of care or services you receive from us, call Member Services at 1-888-260-1010 (TTY: 1-888-542-3821) or write to Member Services. Please remember that complaints about services that are only a benefit under Medicare should be handled through the Healthfirst CompleteCare (HMO SNP) Medicare complaint process. Complaints about services only covered by Medicaid should be handled through the Healthfirst CompleteCare (HMO SNP) Medicaid complaint process. You can choose to use either the Medicare or Medicaid complaints process for complaints about services that Healthfirst CompleteCare (HMO SNP) determines are a benefit under both Medicare and Medicaid.

Most problems can be solved right away. Problems that are not solved over the phone and any complaint that comes in about a Medicaid service will be handled according to the procedures described below. 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 with the Plan:**

To file by phone, call Member Services at 1-888-260-1010 (TTY: 1-888-542-3821), 7 days a week, 8am to 8pm. If you call us after hours, leave a message. We will call you back the next work day. If we need more information to make a decision, we will tell you.

You can write us with your complaint or call the Member Services number and request a complaint form. It should be mailed to:

Healthfirst Medicare Plan
Appeals and Complaints
Unit
P.O. Box 5166
New York, NY 10274-5166
What happens next:

If we don’t solve the problem right away over the phone or after we get your written complaint, we will send you a letter within 15 work days. The letter will tell you:

- who is working on your complaint
- how to contact this person
- if we need more information

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters it will be reviewed by one or more qualified health care professionals.

After we review your complaint:

- We will let you know our decision in 45 days of when we have all the information we need to answer your complaint, but you will hear from us in no more than 60 days from the day we get your complaint. We will write you and will tell you the reasons for our decision.
- When a delay would risk your health, we will let you know our decision in 48 hours of when we have all the information we need to answer your complaint but you will hear from us in no more than 7 days from the day we get your complaint. We will call you with our decision or try to reach you to tell you. You will get a letter to follow up our communication in 3 work days.
- You will be told how to appeal our decision if you are not satisfied and we will include any forms you may need.
- If we are unable to make a decision about your Complaint because we don’t have enough information, we will send a letter and let you know.

Complaint Appeals

If you disagree with a decision we made about your complaint, 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;
- The complaint appeal must be made in writing. If you make an appeal by phone it must be followed up in writing. After your call, we will send you a form which is a summary of 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

Your complaint appeal will be reviewed by one or more qualified people at a higher level than those who made the first decision about your complaint. If your complaint appeal involves clinical matters, your case will be reviewed by one or more qualified health professionals, with at least one clinical peer reviewer, that were 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. You will be given 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
NEW YORK STATE EXTERNAL APPEAL APPLICATION

Complete and send this application within 4 months of the plan’s final adverse determination for health services if you are the patient or the patient’s designee, or within 60 days if you are a provider appealing on your own behalf to DFS.

Mail to: New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209 or Fax to: (800) 332-2729. For help, call (800) 400-8882 or email externalappealquestions@dfs.ny.gov.

<table>
<thead>
<tr>
<th>1. Applicant Name:</th>
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<table>
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<tr>
<th>2. Patient Name:</th>
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<tr>
<th>3. Patient Address:</th>
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<tr>
<td>Street:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<th>4. Patient Phone Number:</th>
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<td>Primary: ( )</td>
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<td>Secondary: ( )</td>
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<th>5. Patient Email Address:</th>
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<th>6. Patient Health Plan:</th>
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<tbody>
<tr>
<td>ID #:</td>
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<tr>
<th>7. Patient’s Physician/Prescriber:</th>
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<tr>
<td>Street:</td>
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<td>City:</td>
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<td>Zip Code:</td>
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<tr>
<th>8. Physician/Prescriber Address:</th>
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<td>Street:</td>
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<td>City:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<th>9. Physician/Prescriber Phone #:</th>
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<tbody>
<tr>
<td>Phone: ( )</td>
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<tr>
<td>Fax: ( )</td>
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<tr>
<th>10. If the patient has a Medicaid Managed Care Plan, has patient requested a fair hearing through Medicaid or received a fair hearing determination?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No □ Don’t know</td>
</tr>
</tbody>
</table>

**11. To be completed if the applicant is the patient’s designee**

Complete this section only if a designee is submitting this appeal on a patient’s behalf. If the patient’s provider is the designee complete section 14 instead of this section.

<table>
<thead>
<tr>
<th>Name of Designee:</th>
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<tr>
<th>Relationship to Patient:</th>
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<table>
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<tr>
<th>Address:</th>
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<td>Street:</td>
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<td>City:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<tr>
<th>Phone Number:</th>
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<tr>
<td>Phone: ( )</td>
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<td>Fax: ( )</td>
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<tr>
<th>Designee Email Address:</th>
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<table>
<thead>
<tr>
<th>12. Reason for Health Plan Denial - check only one and attach a completed physician’s attestation for all expedited appeals and all denial reasons except for Not Medically Necessary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Not medically necessary                                                □ Experimental/investigational for a clinical trial</td>
</tr>
<tr>
<td>□ Experimental/investigational                                            □ Experimental/investigational for a rare disease</td>
</tr>
<tr>
<td>□ Out-of-network and the health plan proposed an alternate in-network service □ Out-of-network referral</td>
</tr>
<tr>
<td>□ Formulary Exception (for individual and small group coverage, other than Medicaid or Child Health Plus)</td>
</tr>
</tbody>
</table>
13. **This appeal may be expedited.** Expedited decisions are made within the timeframes described below, even if the patient, physician or prescriber does not provide needed medical information to the external appeal agent.

<table>
<thead>
<tr>
<th>If Expedited check one:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.</td>
</tr>
<tr>
<td>☐ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient’s life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient’s health, and patient’s physician will complete the Physician Attestation and send it to the Department of Financial Services.</td>
</tr>
<tr>
<td>☐ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug, and patient’s prescribing physician or other prescriber will complete the Physician Attestation and send it to the Department of Financial Services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If Standard check one:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Standard Formulary Exception (72 hours)</td>
</tr>
</tbody>
</table>

*** If expedited you must call 888-990-3991 when the application is faxed***

14. **To be completed if applicant is patient’s provider**

Health care providers have a right to an external appeal of a concurrent or retrospective final adverse determination. This section should be completed by providers appealing on their own behalf or appealing as a patient’s designee. The initial denial and final adverse determination from the first level of appeal must be attached.

- ☐ Provider filing own behalf
- ☐ Provider filing as designee on behalf of patient

<table>
<thead>
<tr>
<th>Provider Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person or Firm Representing Provider (if applicable):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person for Correspondence:</th>
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</thead>
<tbody>
<tr>
<td>Street:</td>
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<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip Code:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Email Address:</td>
</tr>
</tbody>
</table>

I attest that the information provided in this application is true and accurate to the best of my knowledge. I agree not to pursue reimbursement for the service from the patient if a concurrent denial is upheld by the external appeal agent, except to collect a copayment, coinsurance or deductible. If I appeal a concurrent denial on my own behalf, and not as the patient’s designee, I agree to pay the external appeal agent’s fee in full if the health plan’s concurrent denial is upheld, or to pay half of the agent’s fee if the health plan’s concurrent denial is upheld in part. I agree not to commence a legal proceeding against the external appeal agent to review the agent’s decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against the health plan.

| Provider Signature: |
### 15. Description and date(s) of Service:
(Attach any additional information you want considered):

<table>
<thead>
<tr>
<th>Description</th>
</tr>
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</table>

### 16. External Appeal Eligibility (Check one):

- [ ] Attached is final adverse determination from the health plan.
- [ ] Attached is the health plan's letter waiving an internal appeal.
- [ ] Patient requests expedited internal appeal at same time as the external appeal.
- [ ] Health plan did not comply with internal appeal requirements for patient appeal.

### 17. External Appeal Fee

You must enclose a check or money order made out to the health plan if required by the health plan. If the appeal is decided in your favor, the fee will be returned to you.

<table>
<thead>
<tr>
<th>Please check one:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>[ ] Enclosed is a check or money order made out to the health plan.</td>
</tr>
<tr>
<td></td>
<td>[ ] Application was faxed and fee will be mailed to the Department within 3 days.</td>
</tr>
<tr>
<td></td>
<td>[ ] Patient is covered under Medicaid or Child Health Plus.</td>
</tr>
<tr>
<td></td>
<td>[ ] Patient requests fee waiver for hardship and will provide documentation to the health plan.</td>
</tr>
<tr>
<td></td>
<td>[ ] Health plan does not charge a fee for an external appeal or fee is not required.</td>
</tr>
</tbody>
</table>
**PATIENT CONSENT TO THE RELEASE OF RECORDS FOR NEW YORK STATE EXTERNAL APPEAL**

The patient, the patient’s designee, and the patient’s provider have a right to an external appeal of certain adverse determinations made by health plans.

When an external appeal is filed, a consent to the release of medical records, signed and dated by the patient, is necessary. An external appeal agent assigned by the New York State Department of Financial Services will use this consent to obtain medical information from the patient’s health plan and health care providers. The name and address of the external appeal agent will be provided with the request for medical information.

I authorize my health plan and providers to release all relevant medical or treatment records related to the external appeal, including any HIV-related information, mental health treatment information, or alcohol / substance use treatment information, to the external appeal agent. I understand the external appeal agent will use this information solely to make a decision on the appeal and the information will be kept confidential and not released to anyone else. This release is valid for one year. I may revoke my consent at any time, except to the extent that action has been taken in reliance on it, by contacting the New York State Department of Financial Services in writing. I understand that my health plan cannot condition treatment, enrollment, eligibility, or payment on whether I sign this form. I acknowledge that the decision of the external appeal agent is binding. I agree not to commence a legal proceeding against the external appeal agent to review the agent’s decision; provided, however, this shall not limit my right to bring an action against the external appeal agent for damages for bad faith or gross negligence, or to bring an action against my health plan.

If the patient or the patient’s designee submits this application, by signing the Patient Consent to the Release of Records for New York State External Appeal, the patient attests that the information provided in this application is true and accurate to the best of his or her knowledge.

Signature of patient is required below. If the patient is a minor, the document must be signed by their parent or legal guardian. If the patient is deceased, the document must be signed by the patient’s healthcare proxy or executor. If signed by a guardian, power of attorney, healthcare proxy or executor, a copy of the legal supporting document should be included.

| Signature: |
| Print Name: |
| Relationship to patient, if applicable: |
| Patient Name: | Age: |
| Patient’s Health Plan ID#: |
| Date: (required) |
PHYSICIAN ATTESTATION FOR AN EXTERNAL APPEAL

The patient’s physician must complete this attestation for any external appeal of a health plan’s denial of services as experimental/investigational; a clinical trial; a rare disease; out-of-network; or for an expedited appeal. The patient’s prescriber may also request an expedited formulary exception appeal. The Department of Financial Services or the external appeal agent may need to request additional information from you, including the patient’s medical records. This information should be provided immediately.

Mail to: New York State Department of Financial Services, PO Box 7209, Albany NY, 12224-0209
or Fax to: (800) 332-2729.

<table>
<thead>
<tr>
<th>Type of Review Requested:</th>
<th>□ Standard Appeal (30 days), or for a non-formulary drug (72 hours)</th>
<th>□ Expedited Appeal (72 hours), or for a non-formulary drug (24 hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If Expedited check one:</td>
<td>□ Expedited Appeal (72 hours). Denial concerns an admission, availability of care, continued stay, or health care service for which the patient received emergency services and remains hospitalized.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Expedited Appeal (72 hours). 30-day timeframe will seriously jeopardize patient’s life, health, or ability to regain maximum function, or a delay will pose an imminent or serious threat to patient’s health.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Expedited Formulary Exception (24 hours). The patient is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function, or is undergoing a current course of treatment using a non-formulary drug.</td>
<td></td>
</tr>
<tr>
<td>If Expedited complete both:</td>
<td>□ I am aware that the external appeal agent may need to contact me during non-business days for medical information, including medical records, and that a decision will be made by the external appeal agent within 72 hours (or 24 hours for a non-formulary drug) of receiving this expedited appeal request, regardless of whether or not I provide medical information or medical records to the external appeal agent.</td>
<td></td>
</tr>
</tbody>
</table>

During non-business days, I can be reached at: ( )

• For an **expedited appeal**, the patient’s physician, or for a non-formulary drug, the patient’s prescribing physician or other prescriber, must complete the box below and item 14. You must send information to the agent immediately in order for it to be considered.

• For an **experimental/investigational** denial (other than a clinical trial or rare disease treatment) the patient’s physician must complete items 1-10 and 14.

• For a **clinical trial** denial, the patient’s physician must complete items 1-9, 11 and 14.

• For an **out-of-network service** denial (the health plan offers an alternate in-network service that is not materially different from the out-of-network service), the patient’s physician must complete items 1-10 and 14.

• For an **out-of-network referral** denial (the health plan does not have an in-network provider with the appropriate training and experience to meet the health care needs of the patient), the patient’s physician must complete items 1 - 9, 13 and 14.

• For a **rare disease** denial, a physician, other than the treating physician, must complete items 1-9, 12 and 14.

1. Name of Physician (or Prescriber) completing this form:

To appeal an experimental/investigational, clinical trial, out-of-network service, or out-of-network referral denial, the physician must be licensed and board-certified or board-eligible and qualified to practice in the area of practice appropriate to treat the patient. For a rare disease appeal, a physician must meet the above requirements but may not be the patient’s treating physician.
2. Physician (or Prescriber) Address:
   Street:
   City:  State:  Zip Code:

3. Contact Person:

4. Phone Number:  (   )
   Fax:  (   )

5. Physician (or Prescriber) Email:

6. Name of Patient:

7. Patient Address:

8. Patient Phone Number:

9. Patient Health Plan Name and ID Number:

10. Experimental/Investigational Denial or Out-of-Network Service Denial
    (Complete this section for an experimental/investigational denial or an out-of-network service denial only. DO NOT complete this item for appeal of clinical trial participation, rare disease, or an out-of-network referral denial.)

   a. For an Experimental/Investigational Denial:

      As the patient’s physician I attest that (select one without altering):

      OR
      - □ Standard health services or procedures have been ineffective or would be medically inappropriate.

      □ There does not exist a more beneficial standard health service or procedure covered by the health plan.

      AND
      - □ I recommended a health service or pharmaceutical product that, based on the following two documents of medical and scientific evidence outlined in c and d below, is likely to be more beneficial to the patient than any covered standard health service.

   b. For an Out-of-Network Service Denial

      □ As the patient’s physician I attest that the following out-of-network health service (identify service):

      is materially different from the alternate in-network health service recommended by the health plan and (based on the following two documents of medical and scientific evidence) is likely to be more clinically beneficial than the alternate in-network health service and the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

   c. List the documents relied upon and attach a copy of the documents:

      Document #1 Title:
      Publication Name:  Issue Number:  Date:

      Document #2 Title:
      Publication Name  Issue Number:  Date:
d. Supporting Documents

<table>
<thead>
<tr>
<th>Supporting Documents</th>
<th>Check the applicable documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The medical and scientific evidence listed above meets one of the following criteria (Note: peer-reviewed literature does not include publications or supplements sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer.)</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medica, Medline and MELDARS database Health Services Technology Assessment Research;</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>Peer-reviewed abstracts accepted for presentation at major medical association meetings;</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act;</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>The following standard reference compendia: (i) the American Hospital Formulary Service Drug Information; (ii) the National Comprehensive Cancer Network’s Drugs and Biological Compendium; (iii) the American Dental Association Accepted Dental Therapeutics; (iv) Thomson Micromedex DrugDex; or (v) Elsevier Gold Standard’s Clinical Pharmacology; or other compendia as identified by the Secretary of Health and Human Services or the Centers for Medicare &amp; Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal;</td>
<td>□ Document #1 □ Document #2</td>
</tr>
<tr>
<td>Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.</td>
<td>□ Document #1 □ Document #2</td>
</tr>
</tbody>
</table>

11. Clinical Trial Denial

- There exists a clinical trial which is open and for which the patient is eligible and has been or will likely be accepted.

Although not required, it is recommended you enclose clinical trial protocols and related information. The clinical trial must be a peer-reviewed study plan which has been: (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or center, or the Food and Drug Administration in the form of an investigational new drug exemption, or the federal Department of Veteran Affairs, or a qualified non-governmental research entity as identified in guidelines issued by individual NIH Institutes for Center Support Grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the NIH.
### 12. Rare Disease Treatment Denial

If provision of the service requires approval of an Institutional Review Board, include or attach the approval.

- [ ] As a physician, other than the patient’s treating physician, I attest the patient has a rare condition or disease for which there is no standard treatment that is likely to be more clinically beneficial to the patient than the requested service. The requested service is likely to benefit the patient in the treatment of the patient’s rare disease, and such benefit outweighs the risk of the service.

- [ ] I do [ ] I do not have a material financial or professional relationship with the provider of the service (check one).

Check one:
- [ ] The patient’s rare disease currently or previously was subject to a research study by the National Institutes of Health Rare Diseases Clinical Research Network.
- [ ] The patient’s rare disease affects fewer than 200,000 U.S. residents per year.

### 13. Out-of-Network Referral Denial

As the patient’s attending physician, I certify that the in-network health care provider(s) recommended by the health plan do not have the appropriate training and experience to meet the particular health care needs of the patient. I recommend the out-of-network provider indicated below, who has the appropriate training and experience to meet the particular health care needs of the patient and is able to provide the requested health service.

<table>
<thead>
<tr>
<th>Name of out-of-network provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address of out-of-network provider:</td>
</tr>
</tbody>
</table>

Training and experience of out-of-network provider:
- [ ] (e.g., board certification, years treating the condition, # of procedures performed and outcome, any other pertinent information).

### 14. Physician (or Prescriber) Signature

I attest that the above information is true and correct. I understand that I may be subject to professional disciplinary action for making false statements.

<table>
<thead>
<tr>
<th>Signature of Physician (or Prescriber):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

Physician (or Prescriber) Name: (Print Clearly):
CHAPTER 10

Ending your membership in the plan
### Chapter 10. Ending your membership in the plan

**SECTION 1**  
**Introduction** ................................................................. 263  
Section 1.1  This chapter focuses on ending your membership in our plan.... 263

**SECTION 2**  
**When can you end your membership in our plan?** ............... 263  
Section 2.1  You may be able to end your membership because you have Medicare and Medicaid............................................................ 264

Section 2.2  You can end your membership during the the Annual Enrollment Period................................................................. 265

Section 2.3  You may be able to end your membership during the Medicare Advantage Open Enrollment Period................................. 265

Section 2.4  In certain situations, you can end your membership during the Special Enrollment Period.................................................. 266

Section 2.5  Where can you get more information about when you can end your membership? .......................................................... 267

**SECTION 3**  
**How do you end your membership in our plan?** ..................... 267  
Section 3.1  Usually, you end your membership by enrolling in another plan. 267

**SECTION 4**  
**Until your membership ends, you must keep getting your medical services and drugs through our plan**............................ 269  
Section 4.1  Until your membership ends, you are still a member of our plan 269

**SECTION 5**  
**Healthfirst CompleteCare must end your membership in the plan in certain situations** ...................................................... 269  
Section 5.1  When must we end your membership in the plan? ............ 269

Section 5.2  We cannot ask you to leave our plan for any reason related to your health ................................................................. 271

Section 5.3  You have the right to make a complaint if we end your membership in our plan.......................................................... 271
CHAPTER 10: ENDING YOUR MEMBERSHIP IN THE PLAN

SECTION 1  Introduction

Section 1.1  This chapter focuses on ending your membership in our plan

Ending your membership in Healthfirst CompleteCare may be voluntary (your own choice) or involuntary (not your own choice):

- You might leave our plan because you have decided that you want to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
  - If you disenroll from Healthfirst CompleteCare, but are still in need of long-term care services, New York State may require you to join a managed long-term care plan (MLTCP) to continue to receive these services, as long-term care services are no longer covered by New York’s Fee-For-Service Medicaid Program.

- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2  When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.
Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you’ll have to wait for the next period to end your membership or switch to a different plan. You can’t use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

Note: If you’re in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

What type of plan can you switch to? If you decide to change to a new plan, you can choose any of the following types of Medicare plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare with a separate Medicare prescription drug plan

If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without “creditable” prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.)

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

When will your membership end? Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.
### Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the “Annual Open Enrollment Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan
  - or – Original Medicare without a separate Medicare prescription drug plan.

  **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  **Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

### Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make one change to your health coverage during the Medicare Advantage Open Enrollment Period.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage Plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you have until March 31 to join a separate Medicare prescription drug plan to add drug coverage.

- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

### Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you may be eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website [https://www.medicare.gov](https://www.medicare.gov):
  - Usually, when you have moved
  - If you have Medicaid
  - If you are eligible for “Extra Help” with paying for your Medicare prescriptions
  - If we violate our contract with you
  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan
  - Original Medicare *without* a separate Medicare prescription drug plan.

  **If you receive “Extra Help” from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not
enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 1, Section 5 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

  **Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

### Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

You can call **Member Services** (phone numbers are printed on the back of this booklet).

You can find the information in the **Medicare & You 2019** Handbook.

Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.

You can also download a copy from the Medicare website (https://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.

You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### SECTION 3 How do you end your membership in our plan?

**Section 3.1 Usually, you end your membership by enrolling in another plan**

Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:
• You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back of this booklet).

• --or--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

<table>
<thead>
<tr>
<th>If you would like to switch from our plan to:</th>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Another Medicare health plan.</td>
<td>• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Healthfirst CompleteCare when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>• Original Medicare with a separate Medicare prescription drug plan.</td>
<td>• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. You will automatically be disenrolled from Healthfirst CompleteCare when your new plan’s coverage begins.</td>
</tr>
<tr>
<td>• Original Medicare without a separate Medicare prescription drug plan.</td>
<td>• Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Healthfirst CompleteCare when your coverage in Original Medicare begins.</td>
</tr>
<tr>
<td>o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</td>
<td></td>
</tr>
<tr>
<td>o If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 9 for more information about the late enrollment penalty if you join a Medicare drug plan later.</td>
<td></td>
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</tbody>
</table>
For questions about your New York State Medicaid benefits, contact New York State Department of Health Medicaid Program at 1-800-505-5678. TTY users should call 1-888-329-1541. Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid coverage.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave Healthfirst CompleteCare, it may take time before your membership ends and your new Medicare and Medicaid coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5 Healthfirst CompleteCare must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Healthfirst CompleteCare must end your membership in the plan if any of the following happen: (check contract for below)

- If you no longer have Medicare Part A and Part B.

- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. We will assist you with enrolling in another plan for which you are eligible.

- If you move out of our service area.

- If you are away from our service area for more than 90 consecutive days.
If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan’s area. (Phone numbers for Member Services are printed on the back of this booklet.)

- If you become incarcerated (go to prison).
- If you become deceased.
- If you are not a United States citizen or lawfully present in the United States.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.
- If you are no longer eligible for nursing home level of care as determined at any comprehensive assessment for the using the assessment tool prescribed by the New York State Department of Health. However, you will not be disenrolled if we (or the local department of social services) agree that the termination of services would result in you being eligible for nursing home level of care within the succeeding six-month period.

Healthfirst CompleteCare may also end your membership in the plan if any of the following happen:

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you do not pay your medical spend-down, if applicable
- If you knowingly fail to complete and submit any necessary consent or release.
- If you or your family member intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you or your family member continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back of this booklet).

### Section 5.2 We cannot ask you to leave our plan for any reason related to your health

Healthfirst CompleteCare is not allowed to ask you to leave our plan for any reason related to your health.

**What should you do if this happens?**

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

### Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.
CHAPTER 11

Legal notices
# Chapter 11. Legal notices

<table>
<thead>
<tr>
<th>SECTION</th>
<th>Notice text</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Notice about governing law</td>
<td>274</td>
</tr>
<tr>
<td>2</td>
<td>Notice about non-discrimination</td>
<td>274</td>
</tr>
<tr>
<td>3</td>
<td>Notice about Medicare Secondary Payer subrogation rights</td>
<td>274</td>
</tr>
<tr>
<td>4</td>
<td>Privacy Notices</td>
<td>275</td>
</tr>
</tbody>
</table>
SECTION 1  Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2  Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3  Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Healthfirst CompleteCare, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.
SECTION 4  Privacy Notices

Healthfirst Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THE EFFECTIVE DATE OF THIS NOTICE IS July 1, 2016
At Healthfirst (made up of Healthfirst, Inc., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc. and Senior Health Partners, Inc.), we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information, provide you this notice and abide by the terms of this notice. This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights as our valued customer and how you can exercise those rights. Healthfirst is sending this notice to you because our records show that we provide health and/or dental benefits to you under an individual or group policy.

This notice applies to Healthfirst, Inc., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc. and Senior Health Partners, Inc. We are required to follow the terms of this notice until we replace it, and we reserve the right to change the terms of this notice at any time. If we make material changes to our Privacy practices, we will revise it and provide a new Privacy Notice to all persons to whom we are required to give the new notice within 60 days of the change. We will also post any material revision of this notice on our Healthfirst, Inc. website. We reserve the right to make the new changes apply to your health information maintained by us before and after the effective date of the new notice. Every three years, we will notify our members about the availability of the Privacy Notice and how to obtain it.

Healthfirst participates in an Organized Health Care Arrangement (OHCA) under the Health Insurance Portability and Accountability Act. An OHCA is an arrangement that allows Healthfirst and its hospital partners covered by this notice to share protected health information (PHI) about their patients or plan members to promote the joint operations of the participating entities. The organizations participating in this OCHA may use and disclose your health information with each other as necessary for treatment, to obtain payment for treatment, for administrative purposes, to evaluate the quality of care that you receive, and any other joint health care operations of the OHCA.

The covered entities participating in the OHCA agree to abide by the terms of this notice with respect to PHI created or received by the covered entity as part of its participation in the OHCA. The covered entities are: Mount Sinai Health System (Mount Sinai Hospital, Mount Sinai Beth Israel, Mount Sinai St. Luke’s, Mount Sinai West Roosevelt), St. Barnabas Hospital, Medisys Health Network, Maimonides Medical Center, Bronx Lebanon Hospital, NYC Health & Hospitals, The Brooklyn Hospital Center, NorthWell Health, Montefiore Medical Center, Stony Brook University Medical Center, Interfaith Medical Center, St. John’s Episcopal Hospital, SUNY-Downstate Medical Center/University Hospital of Brooklyn and NuHealth. The covered entities, which comprise the OHCA, are in numerous locations throughout the greater New York area. This notice applies to all these sites.

The covered entities participating in the OHCA will share protected health information with each other, as the information is necessary to carry out treatment, payment or healthcare operations. The covered entities that make up OHCA may have different policies and procedures regarding the use and disclosure of health information created and maintained in each of their facilities. Additionally, while all of the entities that make up the OHCA will use this notice for OHCA-related activities, they may use a Notice specific to their own facilities when they are providing services at their organizations. If you have questions about any part of this Notice or if you want more information about the OHCA covered entities, please contact the Privacy Office at 212-801-
HOW WE USE OR SHARE INFORMATION

In this notice, when we talk about “information” or “health information” we mean information we receive directly/indirectly from you through enrollment forms such as your name, address and other demographic data; information from your transactions with us or our providers such as: medical history, health care treatment, prescriptions, health care claims and encounters, health service requests and appeal or grievance information; or financial information pertaining to your eligibility for governmental health programs or pertaining to your payment of premiums.

PERMISSIBLE USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

The following are ways we may use or share information about you.

Health Care Providers’ Treatment Purposes: We may disclose your health information to your doctor, at the doctor’s request, for your treatment; use the information to help pay your medical bills that have been submitted to us by doctors and hospitals for payment; share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, we may give them access to any medical records sent to us by your doctor. We may use or share your information with others to help manage your health care. For example, we might talk to your doctor to suggest a disease management or wellness program that could help improve your health.

Health Care Payment: We may disclose your health information to obtain premiums; to obtain or provide reimbursement for your medical bills; to help a hospital or doctor determine your eligibility or coverage; for billing claims management, and other reimbursement activities; for review of health care services with respect to medical necessity, appropriateness of care or justification of charges; for utilization review activities including preauthorization, precertification, concurrent and retrospective review of services; and for disclosure to consumer reporting agencies of any protected health information related to the collection of premiums or other reimbursement.

Health Care Operations: We may use and disclose your health information to conduct quality assessment and improvement activities; for underwriting, or other activities relating to the creation, renewal or replacement of a contract of health insurance; share your information with others who help us manage, plan or develop our business operations; to authorize business associates to perform data aggregation services; to participate in case management or care coordination. We will not share your information with these outside groups unless they agree to keep it protected, and we are prohibited from using or disclosing your genetic information for underwriting purposes. In some situations we may disclose your health information to another covered entity for the limited health care operations activities and health care fraud and abuse compliance activities of the entity that receives your health information.

Health Care Services: We may use or share your information to give you information about alternative medical treatments and programs or about health related products and services that you may be interested in. For example, we might send you information about asthma, diabetes control or health management programs. We do not sell your information to outside groups who may want to sell their products/services to you, such as a catalog company. We may disclose your health information to our business associates to assist us with these activities.
Health Information Exchange: We may use or share your information electronically via our Health Information Exchange to the hospitals and providers that participate in our OHCA. This information may include visit and clinical information including admissions, discharge and transfer notifications, blood pressure readings, body mass indexes, visit summaries and lab results. We may share information including filled pharmacy claims, medical encounters, and quality care gaps. We will not share information to any physician’s offices, hospitals, clinics, labs or other sites that are not part of the OHCA.

As Required by Law: State and federal laws may require us to release your health information to others. We may be required to report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, New York State and City Departments of Health, Local Districts of Social Service and New York State Attorney General.

We may also use and disclose your health information as follows:
- To someone who has the legal rights to act for you (your personal representative, medical power of attorney or legal guardian) in order to administer your rights as described in this notice;
- To report information to public health agencies if we believe there is a serious health or safety threat;
- To provide information to a court or administrative agency (for example, pursuant to a court order, subpoena or child protective order);
- To report information to a government authority regarding child abuse, neglect or domestic violence; report information for law enforcement purposes;
- To share information for public health activities;
- To share information relative to specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others;
- For research purposes in limited circumstances;
- To a coroner, medical examiner, or funeral director about a deceased person;
- To an organ procurement organization in limited circumstances; and;
- To prevent serious threat to your health or safety or the health or safety of others.

PERMISSIBLE USES and DISCLOSURES THAT REQUIRE YOUR CONSENT OR AUTHORIZATION
If one of the above reasons does not apply to our use or disclosure of your health information, we must get your written permission prior to using or disclosing your health information. For example, most uses and disclosures of psychotherapy notes (if maintained by Healthfirst), uses and disclosures of protected health information for marketing purposes, and disclosures that constitute a sale of protected health information, require that we obtain your written authorization prior to disclosing the information. If you give us written permission to use or disclose your personal health information and change your mind, you may revoke your written permission at any time. Your revocation will be effective for all your health information we maintain, unless we have taken action in reliance on your authorization.
YOUR RIGHTS
The following are your rights with respect to your health information that we maintain. You may make a written request to us to do one or more of the following concerning your health information.

- You have the right to request a copy of this notice to be mailed to you if you received this notice through means other than by U.S. Mail. You can also view a copy of the notice on our web site at http://www.healthfirstny.org.
- You have the right to request copies of your health information. In limited situations, we do not have to agree to your request (i.e.: information contained in psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil criminal or administrative action or proceeding; and information subject to certain federal laws governing biological products and clinical laboratories). In certain other situations, we may deny your request to inspect or obtain a copy of your information. If we deny your request, we will notify you in writing and may provide you with a right to have the denial reviewed. You have the right to ask us to restrict how we use or disclose your information for treatment, payment, or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. While we may honor your request, we are not required to agree to these restrictions.
- You have the right to submit special instructions to us regarding how we send plan information to you that contains protected health information. For example, you may request that we send your information by a specific means (such as U.S. mail or fax) or to a specified address if you believe that you would be harmed if we send your information to you by other means (for example, in situations involving domestic disputes or violence). We will accommodate your reasonable requests as explained above. Even though you requested that we communicate with you through alternative means, we may provide the contract holder with cost information.
- You have the right to inspect and obtain a copy of information that we maintain about you in your “designated record set”. The designated record set is the group of records that we use in order to make decisions about you, and includes enrollment, payment, claims adjudication and case management records.
- You have the right to ask us to make changes to information we maintain about you in your designated record set. These changes are known as amendments. Your written request must include a reason for your request. Denied requests to amend will be communicated to you in writing with an explanation for the denial. You have a right to file a written statement of disagreement.
- You have the right to receive an accounting of certain disclosures of your information made by us during the six (6) years prior to your request. We are not required to provide you with an accounting of the following disclosures:
  - Disclosures made prior to April 14, 2003;
  - Disclosures made for treatment, payment, and health care operations purposes;
  - Disclosures made to you, your personal representative or pursuant to your authorization;
  - Disclosures made incident to a use or disclosure otherwise permitted;
  - Disclosures made to persons involved in your care or other notification purposes;
  - Disclosures made for national security or intelligence purposes;
  - Disclosures made to correctional institutions, law enforcement officials or health oversight agencies; or
  - Disclosures made as part of a limited data set for research, public health, or health care operations purposes.

- You will be notified by Healthfirst following a breach of unsecured protected health information.
EXERCISING YOUR RIGHTS
If you would like to exercise the rights described in this notice, please contact our Privacy Office (below), Monday through Friday, from 9 a.m. - 5 p.m. by phone, email, or in writing. We will provide you with the necessary information and forms for you to complete and return to our Privacy Office. In some cases, we may charge you a cost-based fee to carry out your request. If you have any questions about this notice or about how we use or share information, please contact the Healthfirst Privacy Office.

COMPLAINTS
If you believe that we have violated your privacy rights, you have the right to file a complaint with us or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by calling or writing the Privacy Office (below). We will not take action against you for filing a complaint with us or with the U.S. Department of Health and Human Services:

Healthfirst Privacy Office
PO Box 5183
New York, NY 10274-5183
Phone: 1-212-801-5299
Email: HIPAAPRIVACY@healthfirst.org

Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building, Suite 3312
New York, N.Y. 10278
O.C.R. Hotlines: Voice: (800) 368-1019;
TDD: (800) 537-7697
Email: ocrmail@hhs.gov
Website: http://www.hhs.gov/ocr/
HEALTHFIRST, INC.
New York State Privacy Notice

What is this Notice?

At Healthfirst, Inc. (made up of Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc., Senior Health Partners, Inc. and Healthfirst Insurance Company, Inc.) we appreciate the trust our members place in us and we recognize the importance and sensitivity of protecting the confidentiality of the non-public personal information that we collect about them. We collect non-public personal information from our members to effectively administer our health plans and to provide health care benefits to members of our health plans. Protecting this information is our top priority and we are pleased to share our Privacy Policy with you.

What is “Non-Public Personal Information”?

Non-public personal information (“NPI”) is information that identifies an individual enrolled in a Healthfirst health plan (e.g. Child Health Plus, Healthfirst Medicare Plan, and Healthfirst Insurance Company, Inc.) and relates to: an individual’s enrollment in the plan; an individual’s participation in the plan; an individual’s physical or mental / behavioral health condition; the provision of health care to that individual; or payment for the provision of health care rendered to that individual. NPI does not include publicly available information, or information that is reported or available in an aggregate form, without any personal identifiers.

What types of NPI does Healthfirst collect?

Like all other health care plans, we collect the following types of NPI about our members and their dependents in the normal course of business in order to provide health care services to you:

- Information we receive directly or indirectly from you or city/state governmental agencies through eligibility and enrollment applications and other forms such as: name, address, date of birth, social security number, marital status, dependent information, assets and income tax returns.

- Information about your transactions with us, our affiliated health care providers or others, including, but not limited to, appeals and grievance information, claims for benefits, premium payment history medical records and coordination of benefits information. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

- Information about your activity on our Website.
What NPI does Healthfirst use or disclose to third parties, and why?

We do not disclose NPI to anyone without your written authorization, except as permitted by law. If we were to do so in the future, we will notify you of such change in policy and advise you of your right to instruct us not to make such disclosure. At any time you can tell us not to share any of your personal information with affiliated companies that provide offers other than our products or services. If you wish to exercise your opt-out option, or to revoke a previous opt-out request, you need to provide the following information to process your request: your name, date of birth, and your member identification number.

You can use any of the methods below to request or revoke your opt-out:
- Call us at 1-212-801-6299
- E-mail us at HIPAAPrivacy@healthfirst.org
- Send your opt-out request to us in writing:
  Healthfirst Privacy Office PO Box 5183
  New York, NY 10274-5183

How does Healthfirst treat NPI that relates to your Personal Health Information?

Healthfirst will not disclose any of your non-public health information without your written authorization, except as otherwise permitted by law. Non-public health information is individually identifiable information that we maintain relating to the provision of your health care or payment of your health care, including your medical records and claims payment information.

Under the law, Healthfirst is permitted to disclose non-public health information in order to administer your health care benefits, including: authorizing requests for health care services, payment of claims for services, ensuring quality improvement and assurance practices, resolving appeals or grievance inquiries and any disclosure required to applicable governmental agencies.

If at any time in the future, Healthfirst seeks to disclose your non-public health information in any manner not permitted under the law, we will send you a special consent form to complete and sign before we disclose your information.

What are Healthfirst’s Confidentiality and Security Policies for NPI?

We restrict access to NPI about you to those Healthfirst employees who need to know that information in order to provide services to you. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to guard your NPI. Employees who violate our confidentiality or security policies are subject to disciplinary action, up to and including termination of employment.
Regulation 169 Privacy Notice [2007]
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/TDD 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/TDD 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 https://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-305-0408，TTY/TDD: 1-888-542-3821。
CHAPTER 12

Definitions of important words
Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don’t pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan’s allowed cost-sharing amount. As a member of Healthfirst CompleteCare Plan, you only have to pay our plan’s cost-sharing amounts when you get services covered by our plan. We do not allow providers to “balance bill” or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven’t received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $5,100 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.
**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Complaint** — The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or “copay”)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor’s visit or prescription drug.

**Cost-sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan’s monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A “daily cost sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The general term we use to mean all of the health care services and supplies that are covered by our plan.
Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month’s supply in your plan is 30 days, then your “daily cost-sharing rate” is $1 per day. This means you pay $1 for each day’s supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.
Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.
**Hospice** – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

**Hospital Inpatient Stay** – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

**Income Related Monthly Adjustment Amount (IRMAA)** – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $3,820.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy (LIS)** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.
**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.
Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or “Plan Member”) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “network providers” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.
**Original Medicare** ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

**Part C** – see “Medicare Advantage (MA) Plan.”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.
Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

If you ever lose your low income subsidy (“Extra Help”), you would be subject to the monthly Part D late enrollment penalty if you have ever gone without creditable prescription drug coverage for 63 days or more.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.
Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
### Healthfirst CompleteCare Member Services

<table>
<thead>
<tr>
<th>Method</th>
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<tbody>
<tr>
<td><strong>CALL</strong></td>
<td>1-888-260-1010</td>
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<tr>
<td>Calls to this number are free. 7 days a week from 8am to 8pm. Member Services also has free language interpreter services available for non-English speakers.</td>
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<tr>
<td><strong>TTY</strong></td>
<td>1-888-542-3821</td>
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<tr>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week from 8am to 8pm.</td>
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<tr>
<td><strong>WRITE</strong></td>
<td>Healthfirst Medicare Plan</td>
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<td>Member Services</td>
<td></td>
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<tr>
<td>P.O. Box 5165</td>
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<tr>
<td>New York, NY 10274</td>
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<tr>
<td><a href="mailto:webmaster@healthfirst.org">webmaster@healthfirst.org</a></td>
<td></td>
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<tr>
<td><strong>WEBSITE</strong></td>
<td><a href="http://www.healthfirst.org/medicare">www.healthfirst.org/medicare</a></td>
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**The Health Insurance Information Counseling and Assistance Program (HIICAP)**

HIICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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<tr>
<th>CALL</th>
<th>1-800-701-0501</th>
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<tr>
<td>Monday through Friday 8am to 5pm.</td>
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<tr>
<td><strong>WRITE</strong></td>
<td><strong>New York City:</strong></td>
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<td>New York City Department for the Aging</td>
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<tr>
<td>Office of Public Affairs</td>
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<tr>
<td>2 Lafayette Street</td>
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<td>New York, NY 10007</td>
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<td><strong>Nassau County:</strong></td>
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<td>Nassau County Department of Senior Citizen Affairs</td>
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<tr>
<td>60 Charles Lindbergh Boulevard, Suite #260</td>
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<tr>
<td>Uniondale, NY 11553-3691</td>
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<td><a href="mailto:seniors@hhsnassaucountyny.us">seniors@hhsnassaucountyny.us</a></td>
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<td><strong>Westchester County:</strong></td>
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<tr>
<td>Department of Senior Programs &amp; Services</td>
<td></td>
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<tr>
<td>9 South First Ave, 10th Floor</td>
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<td>Mt. Vernon, NY 10550-3414</td>
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<td><a href="mailto:jsw1@westchestergov.com">jsw1@westchestergov.com</a></td>
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<tr>
<td><strong>WEBSITE</strong></td>
<td><a href="http://www.aging.ny.gov/healthbenefits">www.aging.ny.gov/healthbenefits</a></td>
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