This Medicare Advantage plan offers additional benefits on top of Original Medicare, like dental, vision, hearing, and acupuncture. It is designed for people who don’t qualify for programs that help pay Medicare costs like Extra Help or Medicaid.

New York City and Nassau County
January 1, 2019–December 31, 2019

H3359 001
Snapshot of Benefits

Premium and Deductible  $0 Monthly Premium

Doctor Visits (Primary Care)  $10 Copay

Specialist Care  $45 Copay

Hearing

Preventive Dental

Routine Vision

24/7 Access to Care with Teladoc and the Nurse Help Line  $0 Copay

Preferred Generic Drugs

Post-Hospitalization Meals
<table>
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<th>Section</th>
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</thead>
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<td>Medical and Hospital Benefits (in-network costs)</td>
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<td>Frequently Asked Questions (FAQs) About Healthfirst 65 Plus Plan</td>
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<td>Glossary</td>
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</tbody>
</table>
Healthfirst 65 Plus Plan (HMO) Overview

The Healthfirst 65 Plus Plan offers members a wide range of benefits on top of those included in Original Medicare, including routine and comprehensive dental, hearing coverage and hearing aids, vision coverage, eyeglasses and contact lenses, acupuncture, post-hospitalization meals, and 24/7 access to care with Teladoc and the Nurse Help Line. Plus, you don’t need a referral to see specialists.
This plan may be right for people who do not qualify for programs that help pay Medicare costs like Extra Help (also known as Low Income Subsidy), Medicare Savings Program (MSP), or Medicaid. If you think you may qualify for any of these programs, please call us and we’ll help you find a Healthfirst plan that’s right for you.

Call 1-877-237-1303, 7 days a week, 8am–8pm
(TTY English and other languages 1-888-542-3821)
(TTY Español 1-888-867-4132).

Healthfirst wants to make sure you have all the resources you need to stay healthy. This is why we offer Healthfirst 65 Plus Plan members the added assistance of a service that helps connect them with local community programs. It can support their needs and may even help them save on healthcare costs.

This is a summary document and does not include every service that we cover or list every limitation or exclusion. For a full list of services, look through your Evidence of Coverage (EOC), which can be found online at www.HFMedicareMaterials.org or by calling 1-888-260-1010 (TTY 1-888-542-3821) to request a mailed copy.

Helpful Definitions

Health Maintenance Organization (HMO)
A type of health insurance plan. In most HMOs, you can only go to the hospitals, doctors, and other healthcare providers that have agreements with the plan, except in an emergency. You may also need to get a referral from your primary care doctor before seeing a specialist — however, with the Healthfirst 65 Plus Plan, you will never need a referral to see a specialist.

Premium
The amount of money some people must pay monthly, quarterly, or twice a year to be covered by a health insurance plan or program.

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

Coinsurance
The fee you owe a doctor for your care after you meet your annual deductible. The amount you owe is part of the cost of your care. Your insurance company pays the rest.

What makes you eligible to be a plan member?
- You have both Medicare Part A and Medicare Part B
- You live in either New York City or Nassau County
- You are a United States citizen or are lawfully present in the United States
- 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.
## Useful Contacts

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan Effective Date</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name of Healthfirst Sales Representative</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name of Primary Care Provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phone Number</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Healthfirst Website

**www.healthfirst.org/medicare**

Healthfirst Medicare Plans (for non-members)  
**1-877-237-1303**  
TTY 1-888-542-3821  
7 days a week, 8am–8pm

Healthfirst Member Services  
**1-888-260-1010**  
TTY 1-888-542-3821  
7 days a week, 8am–8pm

Teladoc  
**1-800-TELADOC (1-800-835-2362)**  
TTY 1-800-877-8973  
7 days a week, 24 hours a day

Healthfirst’s Nurse Help Line  
**1-855-NURSE33 (1-855-687-7333)**  
7 days a week, 24 hours a day  
TTY 711

DentaQuest  
**1-800-508-2047**  
Monday to Friday, 9am–6pm

Davis Vision  
**1-800-753-3311**  
Monday to Friday, 8am–11pm,  
Saturday, 9am–4pm, Sunday, 12pm–4pm

Medicare  
**1-800-MEDICARE (1-800-633-4227)**  
TTY 1-877-486-2048  
7 days a week, 24 hours a day  
www.medicare.gov

Elderly Pharmaceutical Insurance Coverage (EPIC) Program  
**1-800-332-3742**  
TTY 1-800-290-9138  
Monday to Friday, 8:30am–5pm

Pharmacy Benefits  
**1-888-260-1010**  
TTY 711  
7 days a week, 24 hours a day

Social Security  
**1-800-772-1213**  
TTY 1-800-325-0778  
Monday to Friday, 7am–7pm
Useful Information

Provider/Pharmacy Directory
The best way to find a doctor or specialist and pharmacy in the Healthfirst network is to visit www.HFDocFinder.org. You may also stop by one of our convenient Community Offices (visit www.healthfirst.org for locations) or call our Member Services at 1-888-260-1010 (TTY 1-888-542-3821) for assistance.

Healthfirst Formulary
To download a copy of your Healthfirst Medicare Plan Formulary, visit www.HFMedicareMaterials.org. You can also pick one up at a Healthfirst Community Office. A formulary is a list of prescription drugs (both generic and brand name) covered by your health plan.

Medicare & You
Visit www.medicare.gov to view the handbook online or order a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week or download a copy of the handbook by visiting www.medicare.gov/medicare-and-you/medicare-and-you.html.

Word to know on this page:

Formulary
To learn what this word means, see the Glossary on page 26
Premiums, Deductibles and Out-of-Pocket Costs

The following are the healthcare costs associated with the Healthfirst 65 Plus Plan:

<table>
<thead>
<tr>
<th>Monthly Premium</th>
<th>Deductible</th>
<th>Maximum Out of Pocket (MOOP) (does not apply to prescription drugs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0 deductible for most medical and hospital benefits</td>
<td>$6,700 for services received from in-network providers</td>
</tr>
</tbody>
</table>

Important information:

You must continue to pay your Medicare Part B premium ($134/month in 2018).

The Medicare Part B premium amount may change for the following year and we will provide updated rates as soon as Medicare releases them.

There is a $100 deductible for comprehensive dental services.

There is a $350 deductible for your Tier 2, Tier 3, Tier 4, and Tier 5 prescription drugs.

This does not apply to prescription drug costs. You will still need to pay your share of the costs for prescription drugs.

With Original Medicare, there's no cap on what you spend on healthcare!

If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and **Healthfirst will pay the full cost for the rest of the year**. Please refer to the “Medicare & You” handbook for Medicare-covered services.

Words to know on this page:

- Original Medicare
- Part B
- Part D

To learn what these words mean, see the Glossary on page 26
Original Medicare vs. Healthfirst 65 Plus Plan Covered Medical and Hospital Benefits
(in-network costs)

Original Medicare is health coverage managed by the federal government and includes just Part A (hospital insurance) and Part B (medical insurance). The Healthfirst 65 Plus Plan is a Medicare Advantage plan that offers the same benefits as Original Medicare, plus other benefits like dental, vision, acupuncture, post-hospitalization meals, 24/7 access to care with Teladoc and the Nurse Help Line, and more. Here’s how they compare:

Services with an asterisk (*) may require prior authorization.

<table>
<thead>
<tr>
<th>Original Medicare Benefits (costs listed are from 2018 unless otherwise indicated)</th>
<th>vs.</th>
<th>What You Pay with Healthfirst 65 Plus Plan (costs listed are for 2019)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital Coverage</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After meeting the Original Medicare Part A deductible ($1,340) for each benefit period: $0 for inpatient days 1–60 (for each benefit period) and $335 per day for inpatient days 61–90 (for each benefit period)  $670 per &quot;lifetime reserve day&quot; after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)</td>
<td>vs.</td>
<td>Plan covers an unlimited number of days for an inpatient hospital stay based on medical necessity. $372 copay per day for days 1–5 $0 per day for days 6+</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Services</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td>vs.</td>
<td>20% of the cost for each outpatient hospital visit $200 copay for each ambulatory surgery visit</td>
</tr>
<tr>
<td><strong>Doctor Visits (Primary Care Physician (PCP) and Specialists)</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>After meeting the Original Medicare Part B deductible ($183): 20% coinsurance for each service</td>
<td>vs.</td>
<td>$10 copay for primary care physician visits; $45 copay for specialist visits. It is very important that you visit your primary care physician and any specialists you need. For help setting up an appointment with your primary care doctor, call 1-888-260-1010 (TTY 1-888-542-3821).</td>
</tr>
</tbody>
</table>
### Preventive Care

<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 for preventive services</td>
<td></td>
<td>$0 copay for Medicare-covered preventive exams</td>
</tr>
<tr>
<td>Examples of preventive care include:</td>
<td>vs.</td>
<td>Preventive care includes a $0 annual wellness visit, which provides height, weight, blood pressure, and other routine exams. Speak to your doctor at your annual visit to ask what preventive services he or she recommends.</td>
</tr>
<tr>
<td>■ colonoscopies</td>
<td></td>
<td>Be sure to take advantage of all the no-cost preventive services you are eligible for each year.</td>
</tr>
<tr>
<td>■ mammograms</td>
<td></td>
<td>For a full list of what you could be eligible for, look through your Evidence of Coverage (EOC), which can be found online at <a href="http://www.HFMedicareMaterials.org">www.HFMedicareMaterials.org</a> or by calling <strong>1-888-260-1010</strong> (TTY 1-888-542-3821) to request a mailed copy.</td>
</tr>
<tr>
<td>■ bone mass measurements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ cardiovascular screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ diabetes screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ and other cancer screenings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Words to know on this page:**
- Preventive
- Colonoscopies
- Mammograms
- Cardiovascular

To learn what these words mean, see the Glossary on page 26.
### Original Medicare Benefits vs. What You Pay With Healthfirst 65 Plus Plan

#### Emergency Care

<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>After meeting the Original Medicare Part B deductible ($183): 20% coinsurance for each service</td>
<td>vs.</td>
<td>$90 copay for domestic and worldwide emergency coverage.</td>
</tr>
<tr>
<td>Original Medicare does not offer worldwide emergency and urgent care coverage</td>
<td></td>
<td>You should seek emergency care if you believe that your health condition requires immediate medical care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you do not think your health condition is severe enough to need emergency care, but you still need medical attention, consider Urgent Care (see below).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Emergency care and urgently needed services are available worldwide. If you used these services in other countries, you’ll need an itemized proof of payment and medical record of the care received to be reimbursed by Healthfirst. The maximum coverage limit amount for emergency and urgent care outside the U.S. is $100,000 per year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Healthfirst 65 Plus Plan will not cover any Part D prescription drugs that you receive as part of your emergency care in another country.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care.</td>
</tr>
</tbody>
</table>

#### Urgently Needed Services

<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td>vs.</td>
<td>$45 copay for domestic and worldwide urgent care coverage.</td>
</tr>
<tr>
<td>Original Medicare does not offer worldwide emergency and urgent care coverage</td>
<td></td>
<td>Urgent care centers are good options for when your primary care provider is on vacation or unable to offer a timely appointment, or for when you are sick or suffer a minor injury outside of regular doctor office hours.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Like emergency care, urgent care is covered worldwide, but any Part D prescription drugs that you receive as part of your urgent care in another country will not be covered. The maximum coverage limit amount for emergency and urgent care outside the U.S. is $100,000 per year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefits of urgent care centers:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- No advance appointment needed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Many have extended hours and are open seven days a week</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- May cost less than visiting the emergency room</td>
</tr>
<tr>
<td>Original Medicare Benefits</td>
<td>vs.</td>
<td>What You Pay With Healthfirst 65 Plus Plan</td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>Diagnostic Services/Labs/Imaging*</td>
<td>$0 for lab services</td>
<td></td>
</tr>
<tr>
<td>Original Medicare pays the full costs of covered diagnostic lab tests</td>
<td>vs.</td>
<td>$50 diagnostic procedures and tests</td>
</tr>
<tr>
<td>For diagnostic radiology services, outpatient x-rays, and therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance for each service after $183 deductible</td>
<td>$100 diagnostic radiology services</td>
<td></td>
</tr>
<tr>
<td>vs.</td>
<td>$15 X-rays</td>
<td></td>
</tr>
<tr>
<td>vs.</td>
<td>20% therapeutic radiology services</td>
<td></td>
</tr>
<tr>
<td>vs.</td>
<td>Diagnostic radiology services include MRIs and CT scans.</td>
<td></td>
</tr>
<tr>
<td>Hearing Services</td>
<td>$45 copay for exam to diagnose and treat hearing and balance issues.</td>
<td></td>
</tr>
<tr>
<td>Original Medicare does not cover any routine hearing services or hearing aids</td>
<td>vs.</td>
<td>$45 copay for routine hearing exam (one every year).</td>
</tr>
<tr>
<td>vs.</td>
<td>$0 copay for hearing aids ($2,000 maximum coverage every three years).</td>
<td></td>
</tr>
</tbody>
</table>

Words to know on this page:

CT
MRI

To learn what these words mean, see the Glossary on page 26.
<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental Services</strong></td>
<td></td>
<td>Preventive dental services:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- $0 copay for cleanings (one every six months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- $0 copay for dental X-rays (one every six months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- $0 copay for oral exams (one every six months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive dental services, $100 deductible, $0 copay after $100 deductible has been met:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Diagnostic and non-routine services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Restorative services (including permanent silver amalgams and composite fillings)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Oral surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Root canal surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Periodontics (prosthetics/crowns)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Dentures, including adjustments and repairs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Plan pays up to $1,500 per year for both preventive and comprehensive dental combined.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>For additional information, including cost shares and exclusions, please refer to your Evidence of Coverage document. You can access Healthfirst 65 Plus Plan’s Evidence of Coverage online at <a href="http://www.HFMedicareMaterials.org">www.HFMedicareMaterials.org</a> or by calling 1-888-260-1010 (TTY 1-888-542-3821) to request a mailed copy.</td>
</tr>
</tbody>
</table>

| Vision Services |     | $45 copay for exam to diagnose and treat diseases and conditions of the eye. Depending on your risk factors, your annual glaucoma screening may be $0. |
|----------------|-----| $0 copay for routine eye exams (one every year). |
|                |     | $0 copay for eyeglasses or contact lenses after cataract surgery. |
|                |     | $0 copay for one pair of contact lenses or eyeglasses (frames and lenses) every 2 years with no prior Medicare-defined cataract surgery requirement: |
|                |     | You can choose from our exclusive collection that features three (3) levels of frames: |
|                |     | - Fashion Frames: $0 copay |
|                |     | - Designer Frames: $20 copay |
|                |     | - Premier Frames: $45 copay |
|                |     | 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 every 2 years. |

Original Medicare **does not cover** any routine dentistry, preventive dental care, or dentures. However, Original Medicare will pay for certain dental services that you get when you’re in a hospital, like if you need to have emergency or complicated dental procedures.

Original Medicare **does not cover** routine vision services. Original Medicare covers some vision services like those related to glaucoma prevention and services after cataract surgery.
<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
</table>
| **Original Medicare Benefits vs. What You Pay With Healthfirst 65 Plus Plan** | We also cover enhanced lenses at an additional copay. These include but are not limited to: ultra-progressive lenses, polycarbonate lenses, anti-reflective coating lenses, polarized lenses, high-index lenses, and more.**  
For additional information, including cost shares and exclusions, please refer to your Evidence of Coverage document. You can access Healthfirst 65 Plus Plan’s Evidence of Coverage online at [www.HFMedicareMaterials.org](http://www.HFMedicareMaterials.org) or by calling 1-888-260-1010 (TTY 1-888-542-3821) to request a mailed copy.**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.  
---  
**Mental Health Services (including inpatient)**  
Original Medicare covers up to 190 days in a lifetime for inpatient mental health care in a psychiatric hospital.  
The inpatient hospital care limit does not apply to inpatient mental services provided in a general hospital  
For services provided in a general hospital:  
- After meeting the Medicare Part A deductible ($1,340) for each benefit period:  
  - $0 for inpatient days 1–60 (for each benefit period) and $335 per day for inpatient days 61–90 (for each benefit period)  
  - $276 copay per day for days 1–6  
  - $0 per day for days 7–190  
- $40 copays for outpatient group therapy and outpatient individual therapy visits  
- $670 per “lifetime reserve day” after day 90 of each benefit period (up to a maximum of 60 days over your lifetime)  
- Plan covers up to 190 days in a lifetime (based on medical necessity) for inpatient mental health care in a freestanding psychiatric hospital. The inpatient hospital care limit does not apply to inpatient mental health services provided in a general acute care hospital.  
- $0 per day for days 7–190  
Psychiatric admissions to general acute care hospitals apply inpatient hospital cost sharing.  
The inpatient mental health cost sharing applies only to stays at a freestanding psychiatric hospital.  
- $40 copays for outpatient group therapy and outpatient individual therapy visits.  
---  
**We also cover enhanced lenses at an additional copay. These include but are not limited to: ultra-progressive lenses, polycarbonate lenses, anti-reflective coating lenses, polarized lenses, high-index lenses, and more.**  
For additional information, including cost shares and exclusions, please refer to your Evidence of Coverage document. You can access Healthfirst 65 Plus Plan’s Evidence of Coverage online at [www.HFMedicareMaterials.org](http://www.HFMedicareMaterials.org) or by calling 1-888-260-1010 (TTY 1-888-542-3821) to request a mailed copy.**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.  
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<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled Nursing Facility (SNF)</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td>A SNF stay is for when you need additional rehabilitative or skilled nursing care after being discharged from hospital stay. Plan covers up to 100 days in a SNF per benefit period. No prior hospital stay is required. $0 per day for days 1–20 $172 copay per day for days 21–100</td>
</tr>
<tr>
<td>$0 per day for days 1–20 each benefit period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$172 per day for days 21–100 each benefit period in 2018</td>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td>3-day hospital stay required</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td>$40 copay per visit for physical therapy</td>
</tr>
<tr>
<td>20% coinsurance after $183 deductible. Physical therapy is subject to caps under Original Medicare</td>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td>$225 copay</td>
</tr>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td>vs.</td>
<td>You need emergency ambulance transportation if you need care that keeps you alive or keeps your health while being moved.</td>
</tr>
<tr>
<td><strong>Routine Transportation</strong></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Original Medicare does not cover routine transportation</td>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Part B Drugs</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td>20% of the cost for Part B drugs such as chemotherapy drugs and others.</td>
</tr>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Services</strong>&lt;sup&gt;*&lt;/sup&gt;</td>
<td></td>
<td>$0 copay for cardiac (heart) and intensive cardiac rehab services</td>
</tr>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td>vs.</td>
<td>$30 copay for pulmonary (lung) rehab services;</td>
</tr>
<tr>
<td>Occupational and speech therapy are subject to caps under Original Medicare</td>
<td></td>
<td>$40 copay for occupational therapy, and speech and language therapy visits.</td>
</tr>
<tr>
<td>$30 copay for Supervised Exercise Therapy (SET) for members that have symptomatic peripheral artery disease (PAD).</td>
<td></td>
<td>20% of the cost for renal dialysis.</td>
</tr>
<tr>
<td>Original Medicare Benefits</td>
<td>vs.</td>
<td>What You Pay With Healthfirst 65 Plus Plan</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>-----</td>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Other Covered Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Podiatry (Foot Care)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original Medicare <strong>does not cover</strong> routine foot care</td>
<td></td>
<td>$25 copay for</td>
</tr>
<tr>
<td>20% coinsurance for medically necessary treatment of foot injuries or diseases after $183 deductible</td>
<td></td>
<td>■ Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>■ Routine foot care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The plan covers 12 routine foot care visits per year</td>
</tr>
<tr>
<td><strong>Medical Equipment/Supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% coinsurance for each service after $183 deductible</td>
<td></td>
<td>$0 for diabetes monitoring supplies, diabetes self-management training, and therapeutic shoes or inserts.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% of the cost for durable medical equipment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examples of durable medical equipment are walkers, wheelchairs, oxygen tanks, crutches, and more.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% of the cost for prosthetic devices (braces, artificial limbs, etc.) and related medical supplies.</td>
</tr>
<tr>
<td><strong>Wellness Programs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Original Medicare <strong>does not cover</strong> acupuncture</td>
<td></td>
<td>Acupuncture – $0 for up to 15 visits every year.</td>
</tr>
<tr>
<td>20% coinsurance after $183 deductible for manual manipulation of the spine if medically necessary to correct a subluxation when provided by a chiropractor or other qualified provider</td>
<td></td>
<td>Chiropractic Care* – $20 copay for manipulation of the spine to correct a subluxation (when one or more of the bones of your spine moves out of position).</td>
</tr>
</tbody>
</table>

**Helpful Definition**

**Benefit Period**

Timeframe that begins the day you are admitted to the hospital as an inpatient and ends when you have been discharged.
<table>
<thead>
<tr>
<th>Original Medicare Benefits</th>
<th>vs.</th>
<th>What You Pay With Healthfirst 65 Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Other Covered Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Healthfirst’s Nurse Help Line</strong></td>
<td></td>
<td>$0 for a 24/7 Nurse Help Line: <strong>1-855-NURSE33</strong> (1-855-687-7333, TTY 711). It’s a free phone service that’s available 24 hours a day, 7 days a week to get wellness advice and help finding a doctor.</td>
</tr>
<tr>
<td>Original Medicare does not provide a nursing helpline</td>
<td>vs.</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Agency Care</strong></td>
<td></td>
<td>You pay nothing.</td>
</tr>
<tr>
<td>You pay nothing for covered home health services</td>
<td>vs.</td>
<td>For you to receive home health services, your doctor must certify that you require those services and will request them from a home health agency. You must be homebound, which means leaving home is very difficult for you.</td>
</tr>
<tr>
<td><strong>Medicare Diabetes Prevention Program</strong></td>
<td></td>
<td>You pay nothing.</td>
</tr>
<tr>
<td>You pay nothing for covered services.</td>
<td>vs.</td>
<td>Program includes health behavior change sessions promoting weight loss through healthy eating and physical activity.</td>
</tr>
<tr>
<td><strong>Teladoc</strong></td>
<td></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Original Medicare does not provide Teladoc services.</td>
<td>vs.</td>
<td>Teladoc connects you with board-certified doctors 24 hours a day, 7 days a week for video or phone chat using your smartphone, tablet, or computer. These doctors can help diagnose, treat, and even write prescriptions for a variety of non-emergency conditions. However, this program is not a substitute for your primary care doctor. You must follow up with your primary care doctor for any treatment provided by Teladoc.</td>
</tr>
<tr>
<td><strong>Post-Hospitalization Meals</strong></td>
<td></td>
<td>$0 copay</td>
</tr>
<tr>
<td>Original Medicare does not provide a meal benefit.</td>
<td>vs.</td>
<td>Up to 42 meals delivered to your home for a duration of up to 14 days after discharge from the hospital. Covered once per calendar year. Prior authorization from the Healthfirst Utilization Management department is required.</td>
</tr>
</tbody>
</table>
### Part D Prescription Drug Benefits

#### Prescription Drug Tiers

<table>
<thead>
<tr>
<th>Tier</th>
<th>Description</th>
<th>Amounts</th>
<th>Coverage Stages</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 1: Preferred Generic Drugs</strong></td>
<td>Tier 1 is your lowest-cost tier. Most generic drugs on the formulary are included in this tier. Most generic drugs contain the same active ingredients as brand drugs and are equally safe and effective. The prescription drug deductible <strong>does not apply to this tier.</strong></td>
<td>Tier 1 drugs, there is no deductible. For Tier 2, Tier 3, Tier 4, and Tier 5 drugs, there is an annual deductible of $350. You must pay the full cost of these drugs until you reach this deductible amount. Once you reach the deductible amount, you pay the amounts shown in the chart on page 20 until your year-to-date payments plus any Healthfirst 65 Plus Plan drug payments total $3,700. After your payments reach $3,700, you will be responsible for most of the cost of your prescription drugs until you reach the catastrophic limit of $5,100. After you reach $5,100, your prescription drug costs will be reduced.</td>
<td>Tier 1: Deductible: $0</td>
<td>Tier 1: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
</tr>
<tr>
<td><strong>Tier 2: Generic Drugs</strong></td>
<td>This is your second lowest-cost tier. Additional generic drugs on the formulary are included in this tier.</td>
<td>Tier 2: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 2: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 2: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
</tr>
<tr>
<td><strong>Tier 3: Preferred Brand Drugs</strong></td>
<td>This is your middle-cost tier. Most drugs on this tier are preferred.</td>
<td>Tier 3: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 3: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 3: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
</tr>
<tr>
<td><strong>Tier 4: Non-Preferred Drugs</strong></td>
<td>This is your second-highest-cost tier and includes non-preferred drugs.</td>
<td>Tier 4: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 4: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 4: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
</tr>
<tr>
<td><strong>Tier 5: Specialty Tier Drugs</strong></td>
<td>The specialty tier is your highest-cost tier. A specialty tier drug is a very high cost or unique prescription drug which may require special handling and/or close monitoring. Specialty drugs may be brand or generic.</td>
<td>Tier 5: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 5: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
<td>Tier 5: The other two drug coverage stages – the coverage gap and the catastrophic coverage stage – are for people with high drug costs. Most members do not reach these stages.</td>
</tr>
<tr>
<td>Tier</td>
<td>Retail Costs (one-month supply)</td>
<td>Retail Costs (three-month supply)</td>
<td>Mail-Order Costs (three-month supply)</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Tier 1 (Preferred Generic)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Tier 2 (Generic)</td>
<td>$10 copay</td>
<td>$30 copay</td>
<td>$10 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 3 (Preferred Brand)</td>
<td>$47 copay</td>
<td>$141 copay</td>
<td>$47 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 4 (Non-Preferred Drug)</td>
<td>$100 copay</td>
<td>$300 copay</td>
<td>$100 copay</td>
<td></td>
</tr>
<tr>
<td>Tier 5 (Specialty Tier)</td>
<td>26% of the cost</td>
<td>26% of the cost</td>
<td>26% of the cost</td>
<td></td>
</tr>
</tbody>
</table>

Even though there is a deductible for Tiers 2–5, you can save money by filling 90-day supplies of these prescriptions through CVS/Caremark Mail Order Pharmacy.

Your costs may change depending on the pharmacy you choose and when you enter another phase of the Part D benefit. For more information on the additional pharmacy-specific cost sharing and the phases of the benefit, please call us at **1-888-260-1010** (TTY 711) to request a mailed copy, or access our Evidence of Coverage online at [www.HFMedicareMaterials.org](http://www.HFMedicareMaterials.org).

Enrollees may receive prescription drugs shipped to their homes through our mail-order pharmacy service. The shipment should arrive approximately 10 days from the date the order is mailed. If the shipment has not arrived during this time period, please contact Member Services at **1-888-260-1010** (TTY 711).

Your costs may differ depending on the supply you receive (30 days, 60 days, or 90 days). Your costs may also differ if you get your drugs from a network pharmacy, a out-of-network pharmacy, a mail-order pharmacy, or a Long Term Care (LTC) facility, or if you need home infusion. Please contact Member Services at **1-888-260-1010** (TTY 711) for specific information about your drug costs.

Remember, if you are not satisfied with your existing plan and want to switch to Healthfirst, you have until March 31 to do so.
About Healthfirst 65 Plus Plan:

Who can join the Healthfirst 65 Plus Plan?
To join Healthfirst 65 Plus Plan, you must be entitled to Medicare Part A, be enrolled in and continue to pay for Medicare Part B, not have End-Stage Renal Disease (ESRD), and live in the Healthfirst 65 Plus Plan service area. Our service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Queens, and Richmond. While anyone can join Healthfirst 65 Plus Plan, the plan is designed for people who don’t qualify for programs that help pay Medicare costs like Extra Help or Medicaid. If you think you may qualify for any of these programs, please call us and we’ll help you find a Healthfirst plan that’s right for you. Call 1-877-237-1303, 7 days a week, 8am–8pm (TTY 1-888-542-3821).

Which doctors, hospitals, and pharmacies can I use?
Healthfirst 65 Plus Plan has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. You can see our plan’s provider and pharmacy directory at our website (www.HFDocFinder.org). Or call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?
Like all Medicare health plans, we cover everything that Original Medicare covers—and more. Here are some medical costs that Healthfirst covers and Original Medicare does not:

• Annual deductible
• Routine eye exams and eyeglasses
• Charges for prescription drugs
• Hearing checkups and hearing aids

• Dental care
• Acupuncture
Comparing Healthfirst 65 Plus Plan with other insurance options:

**How is Healthfirst 65 Plus Plan different from Original Medicare?**
This offers additional benefits on top of Original Medicare (like dental, vision, hearing and acupuncture) and may be right for you if you do not qualify for extra financial help.

**How is Healthfirst 65 Plus Plan different from other Medicare HMOs?**
Unlike other HMOs, you don’t need a referral to see a specialist with the Healthfirst 65 Plus Plan.

**Plan costs:**

**How will I determine my drug costs?**
Our plan groups each medication into one of five “tiers.” See chart on page 20 for a general overview of your drug costs. You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug’s tier and what stage of the benefit you have reached. Earlier in this document, we discussed the benefit stages that occur: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

**Will I have to pay a monthly premium or deductible?**
The Healthfirst 65 Plus Plan has a $0 premium and a $0 deductible for most medical and hospital services. There is an annual deductible of $100 for comprehensive dental services and an annual deductible of $350 for prescription drug tiers 2–5. For tier 1 drugs, there is no deductible.

**Whom should I contact if I need help with healthcare costs?**
Contact your Member Services. The number can be found on page 7.
We’re Here for You in Your Community

Visit our community offices if you have any questions about our Medicare plans or your health benefits:

**BRONX**

412 East Fordham Road  
(entrance on Webster Avenue)

774 East Tremont Avenue  
(between Prospect and Marmion Avenues)

**BROOKLYN**

Bensonhurst  
2236 86th Street  
(between Bay 31st and Bay 32nd Streets)

Downtown Brooklyn  
635 Fulton Street  
(between Hudson Avenue and Rockwell Place)

Sunset Park  
5324 7th Avenue  
(between 53rd and 54th Streets)

**MANHATTAN**

Chinatown  
128 Mott Street, Room 407  
(between Grand and Hester Streets)

28 East Broadway, 5th Floor  
(between Catherine and Market Streets)

Washington Heights  
1467 St. Nicholas Avenue  
(between West 183rd and West 184th Streets)

Harlem  
34 E. 125th Street  
(corner of 125th Street and Madison Avenue)

**QUEENS**

Elmhurst  
40-08 81st Street  
(between Roosevelt and 41st Avenues)

Flushing  
41-60 Main Street, Rooms 201 & 311  
(between Sanford and Maple Avenues)

37-02 Main Street  
(between 37th and 38th Avenues)

Jackson Heights  
93-14 Roosevelt Avenue  
(between Whitney Avenue and 94th Street)

Jamaica Colosseum Mall  
89-02 165th Street  
Main Level

Richmond Hill  
122-01 Liberty Avenue  
(between 122nd and 123rd Streets)

**LONG ISLAND**

Hempstead  
50 Clinton Street  
(between Front Street and Fulton Avenue)

Valley Stream  
2034 Green Acres Mall Sunrise Highway, Level 1  
(in the Macy’s Men’s Wing)
Glossary

Ambulatory Surgery
Takes place in a center that exclusively provides outpatient surgical services to patients not requiring hospitalization and whose expected stay does not exceed 24 hours.

Benefit Period
Begins the day you’re admitted into a hospital or Skilled Nursing Facility (SNF) and ends when you have been discharged. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Cardiovascular Screening
Test for heart disease.

Coinsurance
The fee you owe a doctor for your care after you meet your annual deductible. The amount you owe is part of the cost of your care. Your insurance company pays the rest.

Example: A common coinsurance is 20%. In this case, after you meet your deductible, Healthfirst will pay 80% of the remaining cost. You will pay 20% of the remaining cost.

With Original Medicare, you will pay a 20% coinsurance for most outpatient services. However, with the Healthfirst 65 Plus Plan, you’ll pay a lower copay for many of those same services.

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

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

Example: If your health plan has a $20 PCP copayment, you must pay $20 for a checkup with your Primary Care Provider (PCP).

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

Covered Service
A service that you are entitled to and which your plan will cover under the terms of your plan.

CT
Computed tomography is a medical 3-D imaging technique.
**Deductible**
The amount of money some people must pay in covered expenses each year before their plan or program pays anything for certain covered services. The deductible may not apply to all services.

*Example*: If your deductible is $500, you need to spend $500 for covered healthcare services within one year before your plan or program will start paying for your health services. Your deductible resets once every year.

**Diabetes Screening**
Test for high blood sugar levels.

**Effective Date**
The date on which your plan coverage begins.

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

**Evidence of Coverage (EOC)**
The EOC gives you details about what the plan covers, how much you pay, and more.

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

**Formulary**
A list of prescription drugs (both generic and brand name) covered by your health plan. This may also be called a list of Part D prescription drugs.

**Health Maintenance Organization (HMO)**
A type of health insurance plan. In most HMOs, you can only go to the hospitals, doctors, and other healthcare providers that have agreements with the plan, except in an emergency. You may also need to get a referral from your primary care doctor before seeing a specialist.

**In-Network Provider**
The doctors and hospitals that are part of the Healthfirst network who provide healthcare to our members.

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

**Mammogram**
A diagnostic X-ray of the breast.
Maximum Out-of-Pocket (MOOP)
The most you have to pay each year for expenses covered by your plan (i.e., the sum of the deductible, copay, and coinsurance amounts). Once you reach this amount, you do not pay anything for most services. This does not include your monthly premium costs, any charges from out-of-network healthcare providers, prescription drugs, or services that are not covered by the plan.

Remember, Original Medicare does not have a MOOP or any cap on spending, so your healthcare expenses can be very high over the course of a year.

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

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

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

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

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

Out-of-Network Provider
A healthcare provider (doctor or hospital) that is not a part of a plan network. You will typically pay more if you use a provider that is not in your plan network.

Outpatient
Medical services that do not require an overnight hospital stay.

Part B
Medicare coverage that covers preventive and medically necessary services.

Part D
Adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private-Fee-for-Service Plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare.
Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Preauthorization/Precertification (also known as Prior Authorization)
Some healthcare plans, including Healthfirst, require you to check with them before you get certain services. This is to make sure that these healthcare services are necessary and are covered before you get them so that you will not be responsible for the entire cost. Preauthorization is required for many services, but it is not required in an emergency.

Premium
The amount of money some members must pay monthly, quarterly, or twice a year to be covered by a health insurance plan or program.

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

Primary Care Provider (PCP)
Your Primary Doctor (also known as a Primary Care Doctor, Primary Care Physician, or PCP) is the doctor who provides you with basic healthcare and preventive services to help make sure you stay healthy. Your PCP coordinates most of your care, authorizes treatment, and may refer you to specialists.

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

With Healthfirst 65 Plus Plan, you can see a specialist without getting a referral from your doctor.

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

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

This information is not a complete description of benefits. Contact the plan for more information.

Limitations, copayments, and restrictions may apply.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. Benefits, premiums and/or co-payments/co-insurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The Healthfirst Medicare Plan service area includes the Bronx, Brooklyn, Manhattan, Queens, Staten Island and Nassau and Westchester counties. Plans may vary by county.

This booklet gives you a summary of what we cover and what you pay. It doesn’t list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the “Evidence of Coverage.”

If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or use the Medicare Plan Finder on www.medicare.gov.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at www.medicare.gov or get 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.

This information is available for free in other languages. Please call our Member Services number at 1-888-260-1010, TTY number 1-888-542-3821, 7 days a week, from 8am to 8pm.

Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro número de Servicios a los Miembros al 1-888-260-1010, o al 1-888-867-4132 para los usuarios de TTY, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m.

本資訊有其他語言版本供免費索取。請致電我們的會員服務部，服務時間每週七天，每天上午8時至晚上8時，電話號碼是1-888-260-1010，聽力語言障礙服務專線TTY 1-888-542-3821。

This document is available in other formats, such as braille and large print. This document may be available in a non-English language. For additional information, call us at 1-888-260-1010.

Este documento puede estar disponible en otros formatos como Braille y en letra grande. Este documento puede estar disponible en otros idiomas además del inglés. Para más información, llámenos al 1-888-260-1010.

本文件可以其他形式提供，例如盲文及大字印本。本文件可能有英語之外的其他語言文本。如需更多資訊，請給我們來電，電話號碼是1-888-260-1010。
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 http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)