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

*Ratings are based on a five-star scale from indicators chosen by the New York State Department of Health and are published in its 2014 through 2019 publications of A Consumer’s Guide to Medicaid Managed Care in NYC and on Long Island.
## Important Contact Information

We make it easy to reach us when you need help. The fastest way to get the answers you need is usually online, but we’re also available to talk to you in person at our Healthfirst Community Offices or over the phone.

### ONLINE

| Healthfirst Websites | healthfirst.org (For general information)  
MyHFNY.org (Log in to your secure Healthfirst account)  
HFDocFinder.org (Find a doctor, specialist, urgent care center, or hospital) |
<table>
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<tr>
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<tbody>
<tr>
<td>NY State of Health, the Official Health Plan Marketplace</td>
<td>nystateofhealth.ny.gov</td>
</tr>
<tr>
<td>CVS Pharmacy Mail Order Prescription Service (only)</td>
<td>P.O. Box 2110, Pittsburgh, PA 15230-2110</td>
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</tbody>
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### MAIL

| General Member Correspondence | Healthfirst Medicaid Managed Care Plan  
100 Church Street  
New York, NY 10007 |
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<tbody>
<tr>
<td>CVS Pharmacy Mail Order Prescription Service (only)</td>
<td>P.O. Box 2110, Pittsburgh, PA 15230-2110</td>
</tr>
</tbody>
</table>

### PHONE

| Healthfirst Member Services | 1-866-463-6743  
Monday to Friday, 8am–6pm  
TTY 1-888-542-3821 |
|-------------------------------|--------------------------------------------------------------------------|
| Healthfirst Care Management | 1-800-404-8778  
Monday to Friday, 8:30am–5:30pm  
TTY 1-888-542-3821 |
| CVS Pharmacy Mail Order Prescription Service (only) | 1-800-378-5697  
Monday to Friday, 8am–8:30pm |
| Dental Care | Choose a primary dentist (dental home) for your dental care. These benefits are administered by DentaQuest.  
1-800-508-2047  
Monday to Friday, 9am–6pm |
| Vision Care | Make an appointment for your annual no-cost vision checkup. These benefits are administered by Davis Vision.  
1-800-753-3311  
Monday to Friday, 8am–11pm;  
Saturday, 9am–4pm;  
Sunday, 12pm–4pm |
| Non-Emergency Transportation | Medical Answering Services (Monday to Friday, 7am–6pm):  
NYC Residents: 1-844-666-6270  
Orange County Residents: 1-855-360-3543  
Westchester County Residents: 1-866-883-7865  
Sullivan County Residents: 1-866-573-2148  
medanswering.com (online scheduling available 24/7)  
LogistiCare for Long Island Residents: 1-844-678-1103,  
Monday to Friday, 7am–6pm |
| New York State Department of Health (Complaints) | 1-800-206-8125 |
| New York Medicaid Choice | 1-800-505-5678 |

Medicaid Member Handbook
Welcome To Health Insurance That's Here for You

Thank you for choosing Healthfirst. We're here for you with access to a wide range of care and services to fit your needs and budget, including our large network of doctors and specialists at many top hospitals and medical centers in New York City and on Long Island. Also, we offer in-network urgent care centers to give you extra convenience. Plus, our community wellness events are designed around members just like you. Need answers to your health questions? Healthfirst is here for you from virtually anywhere—online, in person, and over the phone.

Did you know your Healthfirst plan is also the only 5-star-rated (out of five) Medicaid plan in NYC and Long Island five years in a row?* More stars means better plan performance, so you can trust Healthfirst to provide you with access to quality care and service.

This Member Handbook gives you important information—including your benefits, online tools, and more—to help you get to know your new health plan. We also included the following member material in your welcome kit:

- **Quick Reference Drug List:** A list of the most commonly prescribed medications covered under your plan

**Looking for a doctor in the Healthfirst network?**
Check our Provider Directory. Visit MyHFNY.org to view it online, call Member Services to have a copy mailed to you, or return the enclosed card in the postage-paid envelope to: Healthfirst Provider Directory, P.O. Box 5165, New York, NY 10275-0308.

**Ready to get started?**
Continue reading to learn more about your health plan and benefits. You have two ways to register your secure Healthfirst account and get the information you need, including a complete list of plan benefits and coverage:

- Visit MyHFNY.org from your computer or smartphone
- Call Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm, for assistance

**IMPORTANT:**
You need to renew your Healthfirst Medicaid Managed Care plan every year to keep your health coverage. Please write down your plan’s start date and remember to renew with Healthfirst around the same time next year.

*Ratings are based on a five-star scale from indicators chosen by the New York State Department of Health and are published in its 2014 through 2019 publications of A Consumer’s Guide to Medicaid Managed Care in NYC and on Long Island.
Let’s Get Started

As a new Healthfirst member, you should have already received:

☑ Your Member ID Card with Primary Care Provider (PCP) assignment. It identifies you as a Healthfirst member and shows the PCP assigned to you. Of course, you can choose at any time to switch to another doctor in the Healthfirst network. Your card helps you receive care at doctor offices, specialists, urgent care centers, hospitals, and pharmacies in the Healthfirst network. Please carry it with you at all times. If you haven’t received it yet, call Member Services at 1-866-463-6743.

What you can do in the next 30 days to help you get the most from your Healthfirst health plan:

☐ Schedule your annual checkup with your PCP. Make an appointment with your PCP for your free annual checkup.

☐ Choose your dentist* by calling 1-800-508-2047, and make an appointment for your annual free dental checkup and cleanings.

☐ Choose your eye doctor** by calling 1-800-753-3311, and make an appointment for your annual free vision checkup.

☐ Visit MyHFNY.org to sign up for your own secure Healthfirst account. For steps to set up an account, see page V. Or call Member Services and we’ll set up your online account for you.

☐ Complete your Annual Health Assessment. It’s a simple survey that helps us get to know your health needs better. Your survey will arrive in the mail in two to three weeks, or you can complete it online at MyHFNY.org.

☐ Decide whether you want to switch from your assigned PCP to another doctor in the Healthfirst network. Visit HFDocFinder.org to search for doctors in our network, and go to MyHFNY.org to update your PCP yourself or call our Member Services to make the change.

☐ Call and enroll in our free Care Management Program if you need help managing a chronic condition like asthma or diabetes. See page III for more information.

☐ Find a Healthfirst Community Office near you so you can get answers to your health insurance questions in person. Are you more comfortable speaking a language other than English? No problem. Our Member Services reps speak many languages.

*Dental care benefits are administered by DentaQuest.
**Vision care benefits are administered by Davis Vision.
What Should I Know About My Health Plan?

Your Healthfirst Medicaid Managed Care plan offers you access to health benefits including:

- **Primary Care Services** with your PCP (or main doctor) for most of your healthcare needs, such as checkups and health screenings. See page IV for details.
- **Specialist Services** with doctors or nurses who specialize in treating certain conditions, such as hypertension, diabetes, asthma, and arthritis.
- **Urgent Care and ER visits**.
- **Hospital Services** with inpatient (requires overnight stay or longer) and outpatient (does not require an overnight stay) care.
- **Dental Care** with comprehensive dental treatment.
- **Vision Care** with routine eye exams and glasses.
- **Family Planning** that helps you manage the timing of pregnancies.
- **Maternity and Pregnancy Care** that includes doctor visits before and after your baby is born, plus hospital stays. Your baby will also be automatically enrolled into Medicaid.
- **Well-Child Visits** that cover immunizations.
- **Pharmacy benefits** that cover prescription and non-prescription drugs.
- **Lab tests and imaging** (including blood tests and X-rays) to find the cause of illness.
- **Transportation** to help you get to your doctor appointments.

How Else Does Healthfirst Help Me Stay Healthy?

**Care Management Program**

If you’re at risk of developing a chronic illness or are currently living with a chronic health condition like asthma, diabetes or heart disease, COPD, rheumatoid arthritis, HIV, or behavioral health/drug or alcohol abuse, Healthfirst can help. Just call our Provider Services Center at **1-800-404-8778** to connect with a Care Manager.
Access To Many Types of Care

Your Healthfirst Medicaid Managed Care plan gives you access to different types of care. If you’re not sure where to go for healthcare, here’s a general guide:

- For primary care such as checkups and vaccinations, you should see your PCP (main doctor)
- For specialty care, like skincare or foot care, you should see a specialist
- When your PCP is not available and you have an immediate but non-life-threatening health problem, you should go to an urgent care center

Primary Care
Your PCP is the doctor you go to for your healthcare needs. Your PCP can be a general doctor, an OB/GYN, or (in some cases) a specialist.

Specialty Care
As a Healthfirst member, you do not need to get referrals from your PCP to see in-network specialists. However, it is recommended that you talk with your PCP before going to a specialist. Your PCP can help guide you to the most appropriate specialty care for your specific health concern and also recommend specialists to you.

Urgent Care
With access to a robust network of urgent care centers, you can get immediate, non-emergency care whenever your doctor’s office is closed. This can help save you time and money. Urgent care centers are walk-in medical facilities (no advance appointment needed) equipped to handle minor health issues like infections, upset stomach, fevers, sprains, minor fractures and broken bones, stitches, X-rays, and more.
Visit HFDocFinder.org to find an urgent care center near you.

Emergency Care
If you have an emergency, always call 911 or visit the nearest emergency room, especially if you think waiting will worsen your condition. Emergencies are things like uncontrollable bleeding, chest pain, poisoning, and severe allergic reaction.

Did you know? You don’t need preauthorization if you need immediate emergency care. However, please call Healthfirst within 48 hours to let us know you’ve been treated in an emergency room.

Important: Whether you need access to preventive medical services (like a flu shot) or to an urgent care center, you can trust your Healthfirst health insurance plan to be there for you.
Please make sure your doctor, specialist(s), urgent care center, hospital, or lab is in–network before making an appointment. This can help you to avoid any surprise costs when you need care. Why? Because your plan’s coverage doesn’t include out-of-network benefits (except for emergency or urgent care situations, or for out-of-network renal dialysis or other services).

For a complete list of all your covered medical services, please see pages 9–17. You may also call Member Services at 1-866-463-6743 or visit MyHFNY.org. Once there, just sign up for your secure Healthfirst account to view your plan details. Our website is mobile-friendly, so you can access your online account on your smartphone or any mobile device.
What Kind of Online Tools Are Available?

Whether you want to find a doctor, view or print a temporary Member ID card, or learn about all your plan benefits, you can easily do it online 24/7—using your computer, tablet, or even your smartphone. Our website is available in English, Spanish, and Chinese.

Activate your secure Healthfirst account today. Here’s how:

**Step 1**
- Visit MyHFNY.org
- Click “New Users — Sign Up”
- Read the License Agreement, and click “Agree”

**Step 2**
- Fill out your personal information, including your Healthfirst Member ID number. Click “Next”
- Create your Username, Password, and enter your email address. Click “Next”

**Step 3**
- Select your security questions and fill in the answers. Click “Next”
- Verify your information. Click “Complete”

And you’re all set!

Enjoy 24/7 online access to your secure Healthfirst account:
- Search for a doctor, pharmacy, urgent care center, or clinic in our network
- Print out a temporary Member ID card
- View recent medical services and authorizations
- Review your plan benefits
- Change your PCP
- Take an online Annual Health Assessment survey
- Access pharmacy benefits
- See a complete list of prescription drugs covered under your plan

If you’re a member under the age of 18, please call Member Services for special instructions on setting up your secure Healthfirst account.

**Need a new doctor or want to see if your current doctor is in our network?**

Use our easy-to-use online provider directory to get the information you need—including office hours, locations, and hospital affiliation.

Visit HDFinder.org and select your Healthfirst health plan to access our directory. Besides finding Primary Care Providers (PCPs) in our network, you can also search for specialists, dentists, pharmacies, behavioral health providers, hospitals, urgent care centers, and more.

**Step 1**
- Visit HDFinder.org
- Choose your language from the top-right corner (English and Spanish available)
- Select your plan from the list of options: Healthfirst Medicaid Managed Care

**Step 2**
- Use the search box to find a doctor by name, specialty, facility, and more, or click on the shortcuts to search by category

**Step 3**

**Narrow the list of results by:**
- Entering your zip code to find the closest doctor
- Selecting a specialty
- Selecting doctors who are accepting new patients
- Selecting a preferred gender, or
- Selecting other search options

**Manage your prescriptions conveniently and easily online.**

Register your account at caremark.com to quickly order refills, get prescription alerts, check order status, get your medicine mailed to you, and more.

Having trouble getting online?

You can always call our Member Services for assistance. We’ll set up your online account for you and help you with anything else.
What Information Is on My Member ID Card?

Please remember to keep your Healthfirst Member ID card handy so you can get access to care when you need it. And be sure to show it when you receive healthcare services from a doctor or hospital, or when you get a prescription. If you haven’t received your card in the mail yet, please call Member Services.

Your Member ID Number

Jane Doe
Member ID: XX00000X

Provider Name: Dr. John Doe
Provider Phone: 212-900-0000
Dental: 800-508-2047

Benefits
Copy
Non-Preferred Brand Drugs: $3
Generic/Preferred Drugs: $1
Non Prescription (over the counter) Drugs: $0.50

What you pay for some prescriptions

This card does not guarantee coverage.
I agree by the use of this card to release to Healthfirst and its delegates any medical information needed to administer my benefits.

For Members
Member Services: 1-866-463-6743 (or 1-888-542-3821)
Website: healthfirst.org

For Providers
Medical
Eligibility: 1-888-901-1660
Prior Authorization: 1-888-394-4327
Electronic Claims: Payer ID 80141
Paper Claims: Healthfirst Claims Dept. P.O. Box 958438 Lake Mary, FL 32795-8438

Pharmacy
Help Desk: 1-800-364-6331
Claims: CVS Caremark P.O. Box 52136 Phoenix, AZ 85072-2136

Member Services phone number

Mailing address for prescription drug claims

Other contact numbers

What if I lose my Member ID card?

Don’t worry. You’re still covered! We’ve made it easy for you to get a replacement Member ID card as soon as possible:

1. The fastest way is to go online at MyHFNY.org (your secure Healthfirst account) and request a replacement Member ID card (turn to page V for more information), or
2. Call Member Services at 1-866-463-6743, Monday to Friday, 8am–6pm.

Print a temporary ID card

If you need to see a doctor before you get your replacement Member ID card, just visit MyHFNY.org to print a temporary card or pull up an image of your Member ID card on your smartphone or tablet.

You can also call Member Services and they can give you the information you need to give to your doctor.

IMPORTANT: Please make sure we have your correct mailing address in our system. If not, please call Member Services or contact NY State of Health to update your information.
Frequently Asked Questions (FAQs) About Renewing Your Medicaid Managed Care Plan

The easiest way to renew your Medicaid Managed Care plan is to call us at 1-844-201-8346, so please contact us when it’s time to renew your coverage. You can make an appointment by phone, visit us at one of our community offices, or schedule a convenient in-home visit and we’ll come to you. Here are some answers to frequently asked questions about renewing Medicaid coverage:

**Do I need to renew my Medicaid Managed Care plan?**

Yes. Your Medicaid Managed Care plan generally expires **one year after you signed up**, and you need to renew your health plan every year.

**Will I be notified before my coverage expires?**

You will receive a notice from either NY State of Health (NYSOH), the Human Resources Administration (HRA), or your local Department of Social Services (LDSS) before your anniversary date. Make sure you open and read the notice to get all the details about renewing your health insurance plan! The easiest way to renew is to call us at 1-844-201-8346 or come to one of our community offices. **Your coverage will be cancelled if you don’t renew by the requested date.**

**Important:** If you move, please contact Healthfirst and LDSS/HRA/NYSOH to update your mailing address. If any mail is returned undeliverable, your health coverage will automatically be cancelled.

**When should I renew my Medicaid Managed Care plan?**

It’s important to renew your Medicaid coverage once your renewal period starts. You should receive a letter from either NYSOH, HRA, or your local Department of Social Services (LDSS) approximately 60–90 days before your renewal date, or you may receive an email from the NYSOH approximately 45 days before your renewal date. **Just follow the instructions in your reminder notice. If you don’t receive your reminder notice, call us and we will help you.**

**How do I renew my Medicaid Managed Care plan?**

The easiest way to renew your Medicaid Managed Care plan is to call us at 1-844-201-8346 when it’s time to renew your coverage. You can also carefully follow the instructions in your notification letter and handle it yourself.

If you originally enrolled through the NY State of Health website or marketplace, you can renew your coverage through their website.

If you originally enrolled through a paper application, you may be asked to renew by paper application or through the NY State of Health website.

**What happens if you don’t renew?**

Your Medicaid coverage will expire and you will be without health insurance. If you get sick or injured, you won’t have health coverage—even in an emergency—and you will have to pay for any care received.
HERE’S WHERE TO FIND INFORMATION YOU WANT

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YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE NEW SERVICES

Crisis Residence Services for Children and Adults

Starting **December 1, 2020**, Healthfirst Medicaid Managed Care will pay for Crisis Residence services. These are overnight services that treat children and adults who are having an emotional crisis. These services include:

**Residential Crisis Support**
This is a program for people who are age 18 or older with symptoms of emotional distress. These symptoms cannot be managed at home or in the community without help.

**Intensive Crisis Residence**
This is a treatment program for people who are age 18 or older who are having severe emotional distress.

**Children’s Crisis Residence**
This is a support and treatment program for people under age 21. These services help people cope with an emotional crisis and return to their home and community.

To learn more about these services, call Member Services at **1-866-463-6743** (TTY 1-888-542-3821), Monday to Friday, 8am–6pm.

Coverage is provided by Healthfirst PHSP, Inc. Plans contain exclusions and limitations.

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YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE NEW INFORMATION

Specialty Care

Physical Therapy, Occupational Therapy, and Speech Therapy

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

To learn more about these services, call Member Services at **1-866-463-6743** (TTY 1-888-542-3821), Monday to Friday, 8am–6pm.

Coverage is provided by Healthfirst PHSP, Inc.

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YOUR MEMBER HANDBOOK HAS BEEN CHANGED TO INCLUDE NEW SERVICES

Article 29-I Voluntary Foster Care Agency (VFCA) Health Facility Services

Starting July 1, 2021, Healthfirst Medicaid Managed Care will cover Article 29-I VFCA Health Facility services for children and youth under age 21.

29-I VFCA Health Facilities work with families to promote well-being and positive outcomes for children in their care. 29-I VFCA Health Facilities use trauma-informed practices to meet the unique needs of each child.

29-I VFCA Health Facilities may only serve children and youth referred by the local district of social services.

The 29-I VFCA Health Facility services available on July 1, 2021 include:

Core Limited Health-Related Services
  1. Skill Building
  2. Nursing Supports and Medication Management
  3. Medicaid Treatment Planning and Discharge Planning
  4. Clinical Consultation and Supervision
  5. Managed Care Liaison/Administration

and

Other Limited Health-Related Services
  1. Screening, diagnosis, and treatment services related to physical health
  2. Screening, diagnosis, and treatment services related to developmental and behavioral health
  3. Children and Family Treatment and Support Services (CFTSS)
  4. Children’s Home and Community Based Services (HCBS)

Healthfirst Medicaid Managed Care will cover Core Limited Health-Related Services for children and youth placed with a 29-I VFCA Health Facility.

Healthfirst Medicaid Managed Care will cover Other Limited Health-Related Services provided by 29-I VFCA Health Facilities to eligible children and youth.

To learn more about these services, call Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm.
Coverage is provided by Healthfirst PHSP, Inc.

Healthfirst complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-305-0408 (TTY 1-888-867-4132).

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 1-888-542-3821)。

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WELCOME

to Healthfirst’s Medicaid Managed Care Program

We are glad that you enrolled in Healthfirst. This handbook will be your guide to the full range of healthcare services available to you. We want to be sure you get off to a good start as a new member. In order to get to know you better, we will get in touch with you in the next two or three weeks. You can ask us any questions you have, or get help making appointments. If you need to speak with us before we call you, just contact us at 1-866-463-6743.

How Managed Care Plans Work

The Plan, Our Providers, and You

- You may have heard about the changes in healthcare. Many consumers get their health benefits through managed care, which provides a central home for your care. If you were getting behavioral health services using your Medicaid card, now those services may be available through Healthfirst.

- Healthfirst has a contract with the State Department of Health to meet the healthcare needs of people with Medicaid. In turn, we choose a group of healthcare providers to help us meet your needs. These doctors and specialists, hospitals, labs, and other healthcare facilities make up our provider network. You will find a list in our provider directory. If you do not have a provider directory, call 1-866-463-6743 to get a copy, or visit our website at HFDocFinder.org.

- When you join Healthfirst, one of our providers will take care of you. Most of the time, that person will be your Primary Care Provider (PCP). If you need to have a test, see a specialist, or go into the hospital, your PCP will arrange it.

- Your PCP is available to you every day, day and night. If you need to speak to him or her after hours or on weekends, leave a message and how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for healthcare, in some cases you can go to certain doctors for some services. See page 7 for details.

- You may be restricted to certain plan providers if you have been identified as a restricted recipient. Below are examples of why you may be restricted:
  - Getting care from several doctors for the same problem
  - Getting medical care more often than needed
  - Using prescription medicine in a way that may be dangerous to your health
  - Allowing someone other than yourself to use your plan ID card

Confidentiality

We respect your right to privacy. Healthfirst recognizes the trust needed between you, your family, your doctors, and other care providers. Healthfirst will never give out your medical or behavioral health history without your written approval. The only persons that will have your clinical information will be Healthfirst, your Primary Care Provider and other providers who give you care, and your authorized representative. Referrals to such providers will always be discussed with you in advance by your Primary Care Provider or your Health Home Care Manager, if you have one. Healthfirst staff have been trained in keeping strict member confidentiality.

How to Use This Handbook

This handbook will help you when you join a managed care plan. It will tell you how your new healthcare system will work and how you can get the most from Healthfirst. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you. The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out one section at a time.

When you have a question, check this handbook or call our Member Services department. You can also call the managed care staff at your local Department of Social Services.
If you live in any boroughs of NYC or on Long Island, you can also call the New York Medicaid Choice Help Line at 1-800-505-5678.

Help from Member Services

There is someone to help you at Member Services: 1-866-463-6743
English TTY: 1-888-542-3821
Spanish TTY: 1-888-867-4132

- You can call Member Services to get help anytime you have a question. You may call us to choose or change your Primary Care Provider (PCP), to ask about benefits and services, to replace a lost ID card, to report the birth of a baby, or to ask about any change that might affect you or your family’s benefits.

- If you are or become pregnant, your child will become a Healthfirst member on the day he or she is born. This will happen unless your newborn child is in a group that cannot join managed care. You should call us and your LDSS right away if you become pregnant and let us help you to choose a doctor for your baby before he or she is born.

- We offer free sessions to explain our health plan and how we can best help you. It’s a great time for you to ask questions and meet other members. If you’d like to come to one of the sessions, call us to find a time and place that is best for you.

- If you do not speak English, we can help. We want you to know how to use your healthcare plan, no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have a group of people who can help. We will also help you find a PCP who can serve you in your language.

- For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a particular provider’s office is wheelchair-accessible or is equipped with special communications devices. Also, we have services like:

  - TTY service available:
    English 1-888-542-3821
    Spanish 1-888-867-4132
  
  - Information in large print
  - Case management
  - Help in making or getting to appointments
  - Names and addresses of providers who specialize in your disability

- If you or your child are getting care in your home now, your nurse or attendant may not know you have joined our plan. Call us right away to make sure your home care does not stop unexpectedly.

Your Member ID Card

After you enroll, we will send you a welcome letter. Your Healthfirst ID card should arrive within 14 days after your enrollment date. Your card has your PCP’s name and phone number on it. It will also have your Client Identification Number (CIN). If anything is wrong on your Healthfirst ID card, call us right away. Your ID card does not show that you have Medicaid or that Healthfirst is a special type of health plan.

Carry your ID card at all times and show it each time you go for care. If you need care before the card comes, your welcome letter is proof that you are a member. You should keep your Medicaid benefit card. You will need the card to get services that Healthfirst does not cover.
PART I — First Things You Should Know

How to Choose or Change Your Primary Care Provider (PCP)

- You may have already picked your Primary Care Provider (PCP) to serve as your regular doctor. This person could be a doctor or a nurse practitioner. If you do not choose a doctor within 30 days, we will choose one for you. Auto-assignments are performed only if the member has not selected a PCP. If auto-assignment is activated, it looks at member history to select the previously assigned PCP. If there’s no PCP history, a PCP is selected and assigned based on member zip code (address), provider info, and/or quality metrics.

- Each family member can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children. Family practice doctors treat the whole family. Internal medicine doctors treat adults. Member Services (1-866-463-6743) can check to see if you already have a PCP, or help you choose a new PCP.

- To find a doctor, urgent care center, hospital, or lab in the Healthfirst network, check our Provider Directory. The directory lists the address, phone, and special training of the providers. Visit MyHFNY.org to view it online, or call Member Services to order a mailed copy. You can also mail your request to: Member Services, Healthfirst Provider Directory, P.O. Box 5165, New York, NY 10275-0308.

- You may want to find a doctor that:
  - you have seen before
  - understands your health problems
  - is taking new patients
  - can serve you in your language, or
  - is easy to get to

Women can also choose one of our OB/GYN doctors to deal with women’s healthcare.

- In almost all cases, your doctors will be Healthfirst providers. There are four instances when you can still see another provider that you had before you join Healthfirst. In these cases, your provider must agree to work with Healthfirst. You can continue to see your doctor if:
  - You are more than three months pregnant when you joined Healthfirst and you are getting prenatal care. In that case, you can keep your provider until after your delivery through postpartum care
  - At the time you joined Healthfirst, you had a life-threatening disease or condition that got worse with time. In that case, you can ask to keep your provider for up to 60 days
  - At the time you joined Healthfirst, you were being treated for a behavioral health condition. In that case, you can ask to keep your provider through treatment for up to two years
  - At the time you joined Healthfirst, regular Medicaid paid for your home care and you need to keep getting that care for at least 120 days. In that case, you can keep your same home care agency, nurse, or attendant, and the same amount of home care, for at least 90 days

Women do not need a PCP referral to see a plan OB/GYN doctor. They can have routine checkups (twice a year), follow-up care if needed, and regular care during pregnancy.

- We also contract with FQHCs (Federally Qualified Health Centers). All FQHCs give primary and specialty care. Some consumers want to get their care from FQHCs because the centers have a long history in the community. Maybe you want to try them because they are easy to get to. You should know that you have a choice. You can choose any one of the providers listed in our directory. Or you can sign up with a primary care physician at one of the FQHCs that we work with (see how to below). Just call Member Services for help.

You can also get a list of FQHCs on our website at HFDocFinder.org or by calling Member Services.
Healthfirst must tell you about any changes to your home care before the changes take effect.

- If you have a long-lasting illness, like HIV/AIDS or other long-term health problems, you may be able to choose a specialist to act as your PCP. Please call Member Services at 1-866-463-6743 for this type of arrangement.

- If you need to, you can change your PCP in the first 30 days after your first appointment with your PCP. After that, you can change before the 1st of every month without cause, or more often if you have a good reason. You can also change your OB/GYN or a specialist to whom your PCP has referred you.

- If your provider leaves Healthfirst, we will tell you within 15 days from when we know about this. If you wish, you may be able to see that provider if you are more than three months pregnant, or if you are receiving ongoing treatment for a condition. If you are pregnant, you may continue to see your doctor for up to 60 days after delivery. If you are seeing a doctor regularly for an ongoing condition, you may continue your present course of treatment for up to 90 days. Your doctor must agree to work with Healthfirst during this time. If any of these conditions apply to you, check with your PCP or call Member Services.

How to Get Regular Healthcare

- Regular healthcare means exams, regular checkups, shots, or other treatments to keep you well; advice when you need it; and referrals to the hospital or specialists when needed. It means you and your PCP working together to keep you well or to see that you get the care you need.

- Day or night, your PCP is only a phone call away. Be sure to call him or her whenever you have a medical question or concern. If you call after hours or on weekends, leave a message and where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.

- Your care must be medically necessary. The services you get must be needed:
  1. to prevent, or to diagnose and correct, what could cause more suffering, or
  2. to deal with a danger to your life, or
  3. to deal with a problem that could cause illness, or
  4. to deal with something that could limit your normal activities.

- Your PCP will take care of most of your healthcare needs, but you must have an appointment to see your PCP. If ever you can’t keep an appointment, call to let your PCP know.

- As soon as you have a PCP, call to make your first appointment. If you can, prepare for this appointment. Your PCP will need to know as much about your medical background, any problems you have now, any medications you are taking, and the questions you want to ask your PCP. In most cases, your first visit should be within three months of your joining Healthfirst.

- If you need care before your first appointment, call your PCP’s office to explain your concern. He or she will give you an earlier appointment. You should still keep your first appointment to discuss your medical history and ask questions.

- Use the following list as a guide on how long you may have to wait after you request an appointment:
  - adult baseline and routine physicals: within 12 weeks
  - urgent care: within 24 hours
  - non-urgent sick visits: within 3 days
  - routine, preventive care: within 4 weeks
  - first prenatal visit: within 3 weeks during 1st trimester (2 weeks during 2nd, 1 week during 3rd)
  - first newborn visit: within 2 weeks of hospital discharge
  - first family planning visit: within 2 weeks
  - follow-up visit after mental health/substance abuse ER or inpatient visit: 5 days
  - non-urgent mental health or substance abuse visit: 1 week
How to Get Specialty Care

You do not need to get referrals from your PCP to see in-network specialists. However, you should talk with your PCP before going to a specialist so that they can stay aware of your health needs.

- If you need care that your PCP cannot provide, they can suggest a specialist who can.
- If you think a specialist does not meet your needs, ask your PCP if they can help you find a different specialist.
- There are some treatments and services that your PCP must ask Healthfirst to approve before you can get them. Your PCP will be able to tell you what they are.
- If we do not have a specialist in our provider network who can give you the care you need, we will allow you to get care from a specialist outside our network. This is called an out-of-network referral. You, your PCP, or plan provider must ask Healthfirst for approval before you can get an out-of-network referral. If your PCP or plan provider refers you to a provider who is not in our network, you will not be responsible for any costs except the copays described in this handbook.
- Sometimes we may not approve an out-of-network referral because there is a Healthfirst provider who can treat you. If you think our recommended provider does not have the right training or experience to treat you, you can ask us to check if your out-of-network referral is medically needed. You must also ask for a plan appeal. See page 23 to find out how.
- If you need to see a specialist for ongoing care, your PCP may be able to give you a standing referral. This is a referral that lasts for a specified number of visits or length of time. If you have a standing referral, you will not need a new referral for each time you need care.
- If you have a long-term disease or a disabling illness that gets worse over time, your PCP may be able to arrange for:
  - your specialist to act as your PCP; or
  - a referral to a specialty care center that deals with the treatment of your illness (call Member Services for help with getting access).

Get These Services from Our Plan Without a Referral

Women’s Healthcare

It’s always good to let your PCP know of any changes to your health. You do not need a referral from your PCP to see one of our providers if:

- You are pregnant
- You need OB/GYN services
- You need family planning services
- You want to see a midwife
- You need to have a breast or pelvic exam

Family Planning

- Your Medicaid plan includes family planning services such as birth control advice, birth control prescriptions, male and female condoms, pregnancy tests, sterilization, and abortion.
- Starting October 1, 2019, Healthfirst will cover some drugs for infertility. This benefit will be limited to coverage for three cycles of treatment per lifetime. See page 17 for more details.
- In addition to breast and pelvic exams that test for cancer, you can also get tested for sexually transmitted infections during these visits.
- You do not need a referral from your PCP to get these services. You can choose where to get these services. Just use your Healthfirst ID card to see one of our family planning providers. To find a provider, check your plan’s Provider Directory or call Member Services for help.
- You can also use your Medicaid card if you want to go to a doctor or clinic outside our plan. Ask your PCP or call Member Services at 1-866-463-6743 for a list of places to go for these services. Or, call the New York State Growing Up Healthy Hotline (1-800-522-5006) to get the names of family planning providers near you.

HIV and STI Screening

Everyone should know their HIV status. HIV and sexually transmitted infection screenings are part of your ongoing care.

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of your regular healthcare. You do not need a referral when you get this service as part of a family planning visit.

- You can get an HIV or STI test any time you have an office or clinic visit.

- You can get an HIV or STI test any time you have family planning services. Just make an appointment with any family planning provider. If you want an HIV or STI test, but not as part of a family planning service, your PCP can provide or arrange it for you.

- Or, if you’d rather not see one of our Healthfirst providers, you can use your Medicaid card to see a family planning provider outside the Healthfirst network. For help in finding either an in-network provider or a Medicaid provider for family planning services, call Member Services at 1-866-463-6743.

- Everyone should talk to their doctor about having an HIV test. To get free HIV testing or testing where your name isn’t given, call 1-800-541-AIDS (2437) (English) or 1-800-233-SIDA (7432) (Spanish).

Some tests are “rapid tests” and are processed while you wait. The provider who gives you the test will explain the results and arrange for follow-up care if needed. You will also learn how to protect your partner. If your test is negative, we can help you learn to stay that way.

Eye Care

The covered benefits include the needed services of an ophthalmologist, an optometrist, and an ophthalmic dispenser, and include an eye exam and pair of eyeglasses, if needed. Generally, you can get these once every two years, or more often if medically needed. Enrollees diagnosed with diabetes may self-refer for a dilated eye (retinal) examination once in any 12-month period. You just choose one of our participating providers.

New eyeglasses, with Medicaid-approved frames, are usually provided once every two years. New lenses may be ordered more often if, for example, your vision changes more than one-half diopter. If you break your glasses, they can be repaired. Lost eyeglasses, or broken eyeglasses that can’t be fixed, will be replaced with the same prescription and style of frames. If you need to see an eye specialist for care of an eye disease or defect, your PCP will refer you.

Behavioral Health – (Mental Health and Substance Use)

We want to help you get the mental health and drug or alcohol abuse services that you may need. If at any time you think you need help with mental health or substance use, you can see behavioral health providers in our network to see what services you may need. Mental health benefits include services like individual and group counseling, crisis intervention services, substance use disorder services (such as inpatient and outpatient treatment, detoxification services, and more), continuing day treatment, personalized recovery services, and assertive community treatment services. Behavioral health care managers are available 24/7 for members ages 21 and over by contacting Healthfirst Member Services at 1-866-463-6743.

Smoking Cessation

You can get medication, supplies, and counseling if you want help to quit smoking.

Maternal Depression Screening

If you are pregnant and think you need help with depression, you can get a screening to see what services you may need. You can get a screening for depression during pregnancy and for up to a year after your delivery.

Emergencies

You Are Always Covered for Emergencies

An emergency means a medical or behavioral condition:

- that comes on all of a sudden, and
- has pain or other symptoms

An emergency would make a person with an average knowledge of health fear that someone will suffer serious harm to body parts or functions or serious disfigurement without care right away.
Examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won’t stop or a bad burn
- Broken bones
- Trouble breathing, convulsions, or loss of consciousness
- When you feel you might hurt yourself or others
- If you are pregnant and have signs like pain, bleeding, fever, or vomiting
- Drug overdose

Examples of non-emergencies are: colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles.

Non-emergencies may also be family issues, a break-up, or wanting to use alcohol or other drugs. These may feel like an emergency, but they are not reasons to go to the emergency room.

If you have an emergency, here’s what to do:

If you believe you have an emergency, call 911 or go to the emergency room. You do not need your plan’s or your PCP’s approval before getting emergency care, and you are not required to use our hospitals or doctors.

- If you’re not sure, call your PCP or Healthfirst. Tell the person you speak with what is happening. Your PCP or Member Services representative will:
  - tell you what to do at home,
  - tell you to come to the PCP’s office, or
  - tell you to go to the nearest emergency room.

- If you are out of the area when you have an emergency, go to the nearest emergency room.

Remember

You do not need prior approval for emergency services. Use the emergency room only if you have an emergency.

The emergency room should NOT be used for problems like the flu, sore throats, or ear infections.

If you have questions, call your PCP or Healthfirst at 1-866-463-6743.

Urgent Care

When you need medical attention for a non-life-threatening issue and your doctor isn’t available, urgent care centers can help.

- Many have extended hours and are open seven days a week
- Walk-in service without an appointment
- Offer faster service than the emergency room
- Generally have lower copays and costs (if applicable)

You can walk right into an urgent care center for things like: cold and flu, upset stomach and diarrhea, earaches, fevers, asthma*, sprains, suspected broken bones, and more.

You can visit HFDocFinder.org for a list of Urgent Care Centers near you.

Care Outside of the United States

If you travel outside of the United States, you can get urgent and emergency care only in the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. If you need medical care while in any other country (including Canada and Mexico), you will have to pay for it.

*Contact your doctor at the earliest sign of an asthma flare-up to determine if urgent care or the ER would be the best option for your care.
We Want to Keep You Healthy

Besides the regular checkups and the shots you and your family need, here are some other ways to keep you in good health:

- Classes for you and your family
- Stop-smoking classes
- Prenatal care and nutrition
- Grief/Loss support
- Breastfeeding and baby care
- Stress management
- Weight control
- Cholesterol control
- Diabetes counseling and self-management training
- Asthma counseling and self-management training
- Sexually transmitted infection (STI) testing and protecting yourself from STIs
- Domestic violence services

Call Member Services or visit our website at MyHFNY.org to find out more and get a list of upcoming classes.

PART II — Your Benefits and Plan Procedures

The rest of this handbook is for your information when you need it. It lists the covered and the non-covered services. If you have a complaint, the handbook tells you what to do. The handbook has other information you may find useful. Keep this handbook handy for when you need it.

Benefits

Medicaid managed care provides a number of services you get in addition to those you get with regular Medicaid. Healthfirst will provide or arrange for most services that you will need. You can get a few services, however, without going through your PCP. These include emergency care; family planning/HIV testing and counseling; and specific self-referral services, including those you can get from within Healthfirst and some that you can choose to go to any Medicaid provider of the service to get. Please call our Member Services department at 1-866-463-6743 if you have any questions or need help with any of the services below.

Services Covered by Healthfirst

You must get these services from the providers who are in Healthfirst. All services must be medically or clinically necessary and provided or referred by your PCP.

Please call Member Services at 1-866-463-6743 if you have any questions or need help with any of the services below.

Regular Medical Care

- Office visits with your PCP
- Eye/hearing exams
- Specialty care

Preventive Care

- Well-baby care
- Well-child care
- Regular checkups
- Shots for children from birth through childhood
- Access to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for enrollees from birth until age 21
- Access to free needles and syringes
- Smoking-cessation counseling
- HIV education and risk reduction

Maternity Care

- Pregnancy care
- Doctors/midwife and hospital services
- Newborn nursery care
- Screening for depression during pregnancy and up to a year after delivery

Health Home Care Management

Healthfirst wants to meet all of your health needs. If you have multiple health issues, you may benefit
from Health Home Care Management to help coordinate all of your health services.

A Health Home Care Manager can:

- Work with your PCP and other providers to coordinate all of your healthcare
- Work with the people you trust, like family members or friends, to help you plan and get your care
- Help with appointments with your PCP and other providers
- Help to manage ongoing medical issues like diabetes, asthma, and high blood pressure

To learn more about Health Homes, contact Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm.

Home Healthcare

- Must be medically needed and arranged by Healthfirst
- One medically necessary postpartum home health visit; additional visits as medically necessary for high-risk women
- At least two visits to high-risk infants (newborns)
- Other home healthcare visits as needed and ordered by your PCP/specialist

Personal Care/Home Attendant/Consumer Directed Personal Assistance Services (CDPAS)

- Must be medically needed and arranged by Healthfirst
- Personal Care/Home Attendant – Help with bathing, dressing, and feeding, and help with preparing meals and housekeeping
- CDPAS – Help with bathing, dressing, and feeding; help preparing meals and housekeeping; plus home health aide and nursing tasks. This is provided by an aide chosen and directed by you
- If you want more information, contact our Member Services department at 1-866-463-6743

Personal Emergency Response System (PERS)

- This is an item you wear in case you have an emergency
- To qualify for and get this service, you must be receiving personal care/home attendant or CDPAS services

Adult Day Healthcare Services

- Must be recommended by your Primary Care Provider (PCP)
- Provides health education, nutrition, nursing and social services, help with daily living, rehabilitative therapy, pharmacy services, plus referrals for dental and other specialty care

AIDS Adult Day Healthcare Services

- Must be recommended by your Primary Care Provider (PCP)
- Provides general medical and nursing care, substance use supportive services, mental health supportive services, nutritional services, plus socialization, recreational, and wellness/health promotion activities

Therapy for Tuberculosis (TB)

- This is help taking your medication for TB and follow-up care

Hospice Care

- Hospice helps patients and their families with their special needs that come during the final stages of illness and after death
- Must be medically needed and arranged by Healthfirst
- Provides support services and some medical services to patients who are ill and expect to live for one year or less
- You can get these services in your home or in a hospital or nursing home

Children under age 21 who are getting hospice services can also get medically needed curative services and palliative care
If you have any questions about this benefit, you can call Member Services department at 1-866-463-6743.

**Dental Care**

Healthfirst believes that providing you with good dental care is important to your overall healthcare. We offer dental care through a contract with DentaQuest, an expert in providing high-quality dental services. Covered services include regular and routine dental services such as preventive dental checkups, cleaning, X-rays, fillings, and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist.

**How to get dental services:**

1. You need to select a dentist as your primary care dentist
2. If you need help finding an in-network dentist or changing your current primary care dentist, please call 1-800-508-2047. Representatives are there to help you. Many speak your language or have a contract with Language Line Services
3. Show your Healthfirst Member ID card to access dental benefits. You will not receive a separate dental ID card. When you visit your dentist, you should show your plan ID card
4. You don’t need a referral to go to a dental clinic run by an academic dental center. If you wish to obtain dental services at an academic dental center within our service area, please call 1-800-508-2047.

**Orthodontic Care**

Healthfirst will cover braces for children up to age 21 who have a severe problem with their teeth, such as: can’t chew food due to severely crooked teeth, cleft palate, or cleft lip.

**Vision Care**

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider
- Eye exams, generally every two years, unless medically needed more often
- Glasses (new pair of Medicaid-approved frames every two years, or more often if medically needed)
- Low-vision exam and vision aids ordered by your doctor
- Specialist care for eye diseases or defects
- Vision benefits are administered by Davis Vision

**Pharmacy**

- Prescription drugs
- Over-the-counter medicines
- Insulin and diabetic supplies
- Smoking-cessation agents, including OTC products
- Hearing aid batteries
- Enteral formula
- Emergency contraception (six per calendar year)
- Medical and surgical supplies

A pharmacy copayment may be required for some people and for some medications and pharmacy items. There are no copays for the following members or services:

- Consumers younger than 21 years old
- Consumers who are pregnant. Pregnant women are exempt during pregnancy and for the two months after the month in which the pregnancy ends
- Consumers in an OMH or OPWDD Home and Community Based Services (HCBS) Waiver Program
- Consumers in a DOH HCBS Waiver Program for Persons with Traumatic Brain Injury (TBI)
- Family planning drugs and supplies like birth control pills and male or female condoms
- Generic copays
- Drugs to treat mental illness (psychotropic) and tuberculosis
<table>
<thead>
<tr>
<th>Prescription Item</th>
<th>Copayment Amount</th>
<th>Copayment Details</th>
</tr>
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<tbody>
<tr>
<td>Brand name/Non-preferred brand name prescription drugs</td>
<td>$3.00/ $1.00</td>
<td>1 copay charge for each new prescription and each refill</td>
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<tr>
<td>Generic prescription drugs</td>
<td>$1.00</td>
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<td>Over-the-counter drugs, such as for smoking cessation</td>
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- There is a copayment for each new prescription and each refill

- If you transferred plans during the calendar year, keep your receipts as proof of your copayments, or you may request proof of paid copayments from your pharmacy. You will need to give a copy to your new plan

- Certain medications may require that your doctor get prior authorization from us before writing your prescription. Your doctor can work with Healthfirst to make sure you get the medications that you need. Learn more about prior authorization later in this handbook

- You have a choice in where you fill your prescriptions. You can go to any pharmacy that participates in our plan. For more information about your options, please contact Member Services.

Starting April 1, 2020, your maximum pharmacy copayment (copay) will be $50 per quarter year. The copay maximum resets each quarter, regardless of the amount you paid last quarter. The quarters are:

- First quarter: January 1–March 31
- Second quarter: April 1–June 30
- Third quarter: July 1–September 30
- Fourth quarter: October 1–December 31

If you are unable to pay the requested copay you should tell the provider. The provider cannot refuse to give you services or goods because you are unable to pay the copay. (Unpaid copays are a debt you owe the provider.)

To learn more about these services, call Member Services at **1-866-463-6743** (TTY 1-888-542-3821).

**Hospital Care**
- Inpatient care
- Outpatient care
- Lab, X-ray, other tests

**Emergency Care**
- Emergency care services are procedures, treatments, or services needed to evaluate or stabilize an emergency

- After you have received emergency care, you may need other care to make sure you remain in stable condition. Depending on the need, you may be treated in the emergency room, in an inpatient hospital room, or in another setting. This is called post-stabilization services

- For more about emergency services, see page 8

**Specialty Care**
- Includes the services of other practitioners, including:
  - Physical Therapy is limited to 40 visits per calendar year
  - Occupational and speech therapists – Limited to 20 visits each per calendar year
  - Audiologists
  - Midwives
  - Cardiac rehabilitation
  - Podiatrist as medically needed
  - Other specialty care

Limits for physical, occupational, and speech therapists do not apply if you are under age 21, if you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.
To learn more about these services, call Member Services at 1-866-463-6743.

Residential Healthcare Facility Services (Nursing Home)

Covered nursing home services include:
- Medical supervision
- 24-hour nursing care
- Assistance with daily living
- Physical therapy, Occupational therapy
- Speech-language pathology and other services

To get these nursing home services:
- the services must be ordered by your physician, and
- the services must be authorized by Healthfirst

Rehabilitation

Healthfirst covers short-term, or rehabilitation (also known as “rehab”), stays in a skilled nursing home facility.

Long-Term Placement

Healthfirst covers long-term placement in a nursing home facility for members 21 years of age and older.

Long-term placement means you will live in a nursing home.

When you are eligible for long-term placement, you may select one of the nursing homes that are in Healthfirst’s network that meets your needs.

If you want to live in a nursing home that is not part of Healthfirst’s network, you must first transfer to another plan that has your chosen nursing home in its network.

Eligible Veterans, Spouses of Eligible Veterans, and Gold Star Parents of Eligible Veterans may choose to stay in a Veterans’ nursing home.

Healthfirst does not have a Veterans’ Home in its network. If you are an eligible Veteran, spouse of an eligible Veteran, or a Gold Star Parent of an eligible Veteran and you want to live in a Veterans’ Home, we will help arrange your admission. You must transfer to another Medicaid Managed Care health plan that has the Veterans’ Home in its network.

Determining Your Medicaid Eligibility for Long-Term Nursing Home Services

You must apply to your Local Department of Social Services (LDSS) to have Medicaid and/or Healthfirst pay for long-term nursing home services. The LDSS will review your income and assets to determine your eligibility for long-term nursing home services. The LDSS will let you know about any costs you may have to contribute toward your long-term nursing home care.

Questions

If you have any questions about these benefits, call our Member Services department at 1-866-463-6743 (TTY 1-888-542-3821).

Additional Resources

If you have concerns about long-term nursing home care, choosing a nursing home, or the effect on your finances, there are additional resources to help.

- Independent Consumer Advocacy Network (ICAN) provides free and confidential assistance. Call 1-844-614-8800 or visit www.icannys.org
- New York State Office for the Aging
- Health Insurance Information, Counseling and Assistance (HIICAP) provides free counseling and advocacy on health insurance questions. Call 1-800-701-0501
- NY CONNECTS is a link to long-term service and supports. Call 1-800-342-9871 or visit www.nyconnects.ny.gov
- Nursing Home Bill of Rights (NHBOR) describes your rights and responsibilities as a nursing home resident. To learn more about NHBOR, visit www.health.ny.gov/facilities/nursing/rights/

Behavioral Health Care

Behavioral health care includes mental health and substance use (alcohol and drugs) treatment and rehabilitation services. All of our members have access to services to help with emotional health, or to help with alcohol or other substance use issues. You do not need a referral from your PCP.

These services include:
Mental Health Care
- Intensive psychiatric rehab treatment
- Day treatment
- Clinic continuing day treatment
- Inpatient and outpatient mental health treatment
- Partial hospital care
- Rehab services if you are in a community home or in family-based treatment
- Continuing day treatment
- Personalized Recovery-Oriented Services
- Assertive Community Treatment Services
- Individual and group counseling
- Crisis intervention services

Substance Use Disorder Services
- Inpatient and outpatient substance use disorder (alcohol and drug) treatment
- Inpatient detoxification services
- Opioid, including Methadone Maintenance, treatment
- Residential Substance Use Disorder Treatment
- Outpatient alcohol and drug treatment services
- Detox services

Harm-Reduction Services
If you’re in need of help related to substance use disorder, harm-reduction services can offer a complete, patient-oriented approach to your health and well-being. Healthfirst covers services that may help reduce substance use and other related harms. These services include:
- A plan of care developed by a person experienced in working with substance users
- Individual supportive counseling that assists in achieving your goals
- Group supportive counseling in the form of a safe space to talk with others about issues that affect your health and well-being
- Counseling to help you with taking your prescribed medication and continuing treatment
- Support groups to help you better understand substance use and identify coping techniques and skills that will work for you

To learn more about these services, call Member Services at 1-866-463-6743.

Other Covered Services
- Durable Medical Equipment (DME)/hearing aids/prosthetics/orthotics
- Court-ordered services
- Case management
- Help getting social support services
- Federally Qualified Health Centers (FQHCs)
- Family planning
- Services of a podiatrist as medically needed

Children and Family Treatment and Support Services
You may already get similar services with your State Medicaid card. Starting on the dates below, use your Healthfirst Medicaid Managed Care Member ID card to get the service.

January 1, 2019
On January 1, 2019, use your Healthfirst Medicaid Managed Care Member ID card to get Children and Family Treatment and Support Services. These services include:
- Other Licensed Practitioner (OLP). This benefit lets you get individual, group, or family therapy where you are most comfortable.
- Psychosocial Rehabilitation (PSR). This benefit helps you relearn skills to help you in your community. This service was called “Skill Building.”
- Community Psychiatric Supports and Treatment (CPST). This benefit helps you stay in your home and communicate better with family, friends, and others. This service was called “Intensive In Home Services,” “Crisis Avoidance Management & Training,” or “Intensive In Home Supports and Services.”

If you are under 21 years old and have federal Social Security Insurance disability status or have been determined Social Security Insurance-Related
by New York State, use your state Medicaid card for these Children and Family Treatment and Support Services.

Healthfirst Medicaid Managed Care Plan will cover more behavioral health services for children and youth. You can get these services by using your health plan card.

Some of these services may already be covered by Healthfirst Medicaid Managed Care Plan for certain eligible children under age 21.

Effective July 1, 2019, the following services became available to members under the age of 21:

- Office of Alcoholism and Substance Abuse Services (OASAS) Outpatient – Clinic
- OASAS Outpatient – Rehabilitation Programs
- OASAS Opioid Treatment Program Services
- OASAS Chemical Dependence Inpatient Rehabilitative Services
- Injections for Behavioral Health Related Conditions
- Children and Family Treatment and Support Services (CFTSS), including:
  - Other Licensed Practitioner (OLP)
  - Psychosocial Rehabilitation (PSR)
  - Community Psychiatric Supports and Treatment (CPST)
  - Family Peer Support Services
- Office of Mental Health (OMH) Outpatient Services
- OMH designated Serious Emotional Disturbance (SED) Clinic Services
- Assertive Community Treatment (ACT)
- Continuing Day Treatment
- Personalized Recovery Oriented Services (PROS)
- Partial Hospitalization
- Psychiatric Services
- Psychological Services
- Comprehensive Psychiatric Emergency Program (CPEP) including Extended Observation Bed
- Inpatient Psychiatric Services

Healthfirst Medicaid Managed Care Plan will cover these services for all eligible children and youth under age 21, including those:

- With Supplemental Security Income (SSI);
- Who have federal Social Security Disability Insurance (SSDI) status; or
- Who have been determined certified disabled by a New York State Medical Disability Review

To learn more about these services, call Member Services at 1-866-463-6743.

Starting January 1, 2020, Healthfirst Medicaid Managed Care will cover more Children and Family Treatment and Support Services (CFTSS). These services help children and their families improve their health, well-being, and quality of life.

CFTSS are for children under age 21 with behavioral health needs. These services may be provided at home or in the community. The additional CFTSS available on January 1, 2020 include:

Youth Peer Support and Training. This benefit is provided by a credentialed Youth Peer Advocate or by a Certified Recovery Peer Advocate with a youth focus who has similar experiences.

Get support and assistance with

- developing skills to manage health challenges and be independent.
- feeling empowered to make decisions.
- making connections to natural supports and resources.
- transitioning to the adult health system when the time is right.

Crisis Intervention. Professional help at home or in the community when a child or youth is distressed and can’t be helped by family, friends, and other supports, including support and help with using crisis plans to de-escalate the crisis and prevent or reduce future crises.

These services may already be covered by Healthfirst Medicaid Managed Care for certain eligible children under age 21. If you are getting these services now, your care will not change.

To learn more about these services, call Member Services at 1-866-463-6743 (TTY 1-888-542-3821).
Children’s Home and Community Based Services

New York State covers Children’s Home and Community Based Services (HCBS) under the Children’s Waiver. Effective October 1, 2019, Healthfirst Medicaid Managed Care covers children’s HCBS for members participating in the Children’s Waiver and provides care management for these services.

Children’s HCBS offer personal, flexible services to meet the needs of each child/youth. HCBS are provided where children/youth and families are most comfortable and support them as they work towards goals and achievements.

Who Can Get Children’s HCBS?

Children’s HCBS are for children and youth who

- need extra care and support to remain at home/in the community.
- have complex health, developmental, and/or behavioral health needs.
- want to avoid going to the hospital or a long-term care facility.
- are eligible for HCBS and participate in the Children’s Waiver.

Members under age 21 can get the following services from their health plan:

- Community Habilitation
- Day Habilitation
- Caregiver/Family Support and Services
- Community Self Advocacy Training and Support
- Prevocational Services (must be age 14 or older)
- Supported Employment (must be age 14 or older)
- Respite Services (Planned Respite and Crisis Respite)
- Palliative Care
- Environmental Modifications
- Vehicle Modifications
- Adaptive and Assistive Equipment
- Youth Peer Support Services and Training
- Crisis Intervention

Children/youth participating in the Children’s Waiver must receive care management. Care management provides a person who can help you find and get the services that are right for you.

- If you are getting care management from a Health Home Care Management Agency (CMA), you can stay with your CMA. Healthfirst Medicaid Managed Care will work with your CMA to help you get the services you need.
- If you are getting care management from the Children and Youth Evaluation Service (C-YES), Healthfirst Medicaid Managed Care will work with C-YES and provide your care management.

To learn more about these services, call Member Services at 1-866-463-6743 (TTY 1-888-542-3821).

National Diabetes Prevention Program (NDPP) Services

If you are at risk of developing type 2 diabetes, Healthfirst Medicaid Managed Care covers services that may help.

Starting February 1, 2020, Healthfirst Medicaid Managed Care will cover diabetes prevention services through the National Diabetes Prevention Program (NDPP). This benefit will cover 22 NDPP group training sessions over the course of 12 months.

The National Diabetes Prevention Program is an educational and support program designed to assist at-risk people from developing type 2 diabetes. The program consists of group training sessions that focus on the long-term, positive effects of healthy eating and exercise. The goals for these lifestyle changes include modest weight loss and increased physical activity. NDPP sessions are taught using a trained lifestyle coach.

Eligibility

You may be eligible for diabetes prevention services if you have a recommendation by a physician or other licensed practitioner and

- are at least 18 years old,
- are not pregnant,
- are overweight, and
have not been previously diagnosed with type 1 or type 2 diabetes.

And you meet one of the following criteria:

- You have had a blood test result in the prediabetes range within the past year, or
- You have been previously diagnosed with gestational diabetes, or
- You score 5 or higher on the Centers for Disease Control and Prevention (CDC)/American Diabetes Association (ADA) Prediabetes Risk Test.

Talk to your doctor to see if you qualify to take part in the NDPP.

To learn more about these services, call Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm.

Benefits You Can Get from Healthfirst or With Your Medicaid Card

For some services, you can choose where to get your care. You can get these services by using your Healthfirst membership card. You can also go to providers who will take your Medicaid Benefit card. Call Member Services if you have questions.

Family Planning

You can go to any doctor or clinic that takes Medicaid and offers family planning services. Or visit one of our family planning providers. Either way, you do not need a referral from your PCP.

You can get birth control drugs and devices (IUDs and diaphragms) that are available with a prescription, as well as emergency contraception, sterilization, pregnancy testing, prenatal care, and abortion services.

You can also see a family planning provider for HIV and sexually transmitted infection (STI) testing and treatment and counseling related to your test results. Screenings for cancer and other related conditions are also included in family planning visits.

Infertility Services

If you are unable to get pregnant, your Medicaid plan covers services that may help.

Effective October 1, 2019, Healthfirst Medicaid Managed Care plans cover some drugs for infertility. This benefit is limited to coverage for three cycles of treatment per lifetime.

Your Medicaid plan also covers services related to prescribing and monitoring the use of infertility drugs, including:

- Office visits
- X-rays of the uterus and fallopian tubes
- Pelvic ultrasounds
- Blood testing

Eligibility for Infertility Services

You may be eligible for infertility services if

- you are 21–34 years old and are unable to get pregnant after 12 months of regular, unprotected sex; or
- you are 35–44 years old and are unable to get pregnant after six months of regular, unprotected sex.

To learn more about these services, please call Member Services at 1-866-463-6743.

HIV Testing and Counseling

You can get this service any time from your PCP or in-network doctors. When you get this service as part of a family planning visit, you can go to any doctor or clinic that takes Medicaid and offers family planning services.

Everyone should talk to their doctor about having an HIV test. To access free HIV testing or testing where your name isn’t given, call 1-800-541-AIDS (2437) (English) or 1-800-233-SIDA (7432) (Spanish).

TB Diagnosis and Treatment

You can go to your PCP or to the county public health agency for diagnosis and/or treatment of TB. You do not need a referral to go to the county public health agency.
Benefits Using Your Medicaid Card Only

There are some services Healthfirst does not provide. You can get these services from a provider who takes Medicaid by using your Medicaid Benefit card.

Transportation

Emergency: If you need emergency transportation, call 911.

Non-Emergency: Non-emergency medical transportation will be covered by regular Medicaid.

To get non-emergency transportation, you or your provider must call either LogistiCare Solutions for Long Island residents (Nassau County and Suffolk County) at 1-844-678-1103, or contact Medical Answering Service (MAS) at the web address or number listed below for New York City or the county you live in. If possible, you or your provider should call for non-emergency transportation at least three days before your medical appointment and provide your Medicaid identification number (example: AB12345C). Non-emergency medical transportation includes bus, taxi, ambulette, and public transportation.

Visit medanswering.com to schedule transportation online 24/7, or call an office near you, Monday to Friday, 7am–6pm.

- New York City: 1-844-666-6270
- Orange: 1-855-360-3543
- Westchester: 1-866-883-7865
- Sullivan: 1-866-573-2148

If you require an attendant to go with you to your doctor’s appointment or if your child is the member of the plan, transportation is also covered for the attendant or parent or guardian.

If you have questions about transportation, please call Medical Answering Services if you live in NYC, or in Orange, Sullivan, or Westchester County, or call LogistiCare if you live in Long Island.

If you have an emergency and need an ambulance, you must call 911.

Developmental Disabilities

- Long-term therapies

- Day treatment
- Housing services
- Medicaid Service Coordination (MSC) program
- Services received under the Home and Community Based Services Waiver
- Medical Model (Care-at-Home) Waiver Services

Services NOT Covered

These services are not available from Healthfirst or Medicaid. If you get any of these services, you may have to pay the bill:

- Cosmetic surgery if not medically needed
- Personal and comfort items
- Services from a provider who is not part of Healthfirst, unless it is a provider you are allowed to see as described elsewhere in this handbook, or unless Healthfirst or your PCP sends you to that provider

You may have to pay for any out-of-network service that your PCP does not approve. Or, if before you get a service, you agree to be a “private pay” or “self-pay” patient, you will have to pay for the service.

This includes:

- Non-covered services (listed above)
- Unauthorized services
- Services provided by providers not part of Healthfirst

If You Get a Bill

If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Healthfirst at 1-866-463-6743 right away. Healthfirst can help you understand why you may have gotten a bill. If you are not responsible for payment, Healthfirst will contact the provider and help fix the problem for you.

You have the right to ask for a fair hearing if you think you are being asked to pay for something Medicaid or Healthfirst should cover. See the Fair Hearing section later in this handbook.
If you have any questions, call Member Services at 1-866-463-6743.

Service Authorization

Prior Authorization

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. This is called prior authorization.

You or someone you trust can ask for this. The following treatments and services must be approved before you get them:

- All out-of-network services (Non-emergent services)
- Acute rehabilitation admissions
- All cosmetic surgery (medically necessary)
- All elective admissions to a hospital
- Air ambulance
- DME (diabetic and dressing supplies do not require authorization)
- Electromyogram (EMG)/nerve conduction studies
- Home health services
- Home Care InteliHealth Monitoring
- Pain management services
- Physical Therapy/Occupational Therapy/Speech Therapy
- Procedures and equipment for erectile dysfunction
- Skilled nursing facility admissions
- Transplant
- Injectable (through our Specialty Pharmacy network)
- Dental (please remember that for you to receive this service, your provider will have to contact DentaQuest at 1-800-508-2047)
- Vision/Glasses (please remember that for you to receive this service, your provider will have to contact Davis Vision at 1-800-753-3311)

Asking for approval of a treatment or service is called a service authorization request. To get approval for these treatments or services, you or your doctor need to call Member Services at 1-866-463-6743 or send your request in writing to:

Healthfirst Medicaid Managed Care Plan
100 Church Street
New York, NY 10007

For preauthorization or to notify Healthfirst of an admission, please contact:

Medical Management Department
Phone: 1-888-394-4327; Fax: 1-646-313-4603
Monday to Friday, 8:30am–5:30pm.

You will also need to get prior authorization if you are getting one of these services now but need to continue or get more of the care. 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. We check that the service you are asking for is covered under your health plan. 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 medically acceptable 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 healthcare 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 or may be a healthcare professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, we use to make decisions about 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 case will be handled under the standard review process.

We will fast track your review if:

- A delay will seriously risk your health, life, or ability to function;
Your provider says the review must be faster;
You are asking for more of a service you are getting right now.

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. (See also the Plan Appeals and Fair Hearing sections later in this handbook.)

**Timeframes for prior authorization requests**

- **Standard review** — We will make a decision about your request within three workdays 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 one workday 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. We will tell you by the 14th day if we need more information.

- **Fast-track review** — We will make a decision within one workday of when we have all the information we need. You will hear from us no later than 72 hours after we received your request. We will tell you within one workday if we need more information.

**Special timeframes for other requests**

- If you are in the hospital or have just left the hospital and you are asking for home health care, we will make a decision within 72 hours of your request.

- If you are getting inpatient substance use disorder treatment and you ask for more services at least 24 hours before you are to be discharged, we will make a decision within 24 hours of your request.

- If you are asking for mental health or substance use disorder services that may be related to a court appearance, we will make a decision within 72 hours of your request.

- If you are asking for an outpatient prescription drug, we will make a decision within 24 hours of your request.

- A step therapy protocol means we require you to try another drug before we will approve the drug you are requesting. If you are asking for approval to override a step therapy protocol, we will make a decision within 14 days of your request.

If we need more information to make either a standard or fast-track decision about your service request, 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 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 our Medical Management at 1-888-394-4327 or writing to:

**Healthfirst Medical Management Department**
**P.O. Box 5166**
**New York, NY 10274-5166**

You or your representative 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 1-800-206-8125.

We will notify you by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If we do not respond
to a request to override a step therapy protocol on time, your request will be approved.

If you think our decision to deny your service authorization request is wrong, you have the right to file a Plan Appeal with us. See the Plan Appeal 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 make these decisions.

Timeframes for other decisions about your care

- 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.
- We must tell you at least 10 days before we make any decision about long-term services and supports, such as home healthcare, personal care, CDPAS, adult day healthcare, and nursing home care.
- 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 all information we need 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. These notices are not bills. 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.

How Our Providers Are Paid

You have the right to ask us whether we have any special financial arrangement with our physicians that might affect your use of healthcare services. You can call Member Services if you have specific concerns. We also want you to know that most of our providers are paid in one or more of the following ways:

- If our PCPs work in a clinic or health center, they probably get a salary. The number of patients they see does not affect this.
- Our PCPs who work from their own offices may get a set fee each month for each patient for whom they are the patient’s PCP. The fee stays the same whether the patient needs one visit or many—or even none at all. This is called capitation.
- Sometimes providers get a set fee for each person on their patient list, but some money (maybe 10%) can be held back for an incentive fund. At the end of the year, this fund is used to reward PCPs who have met the standards for extra pay that were set by the Plan.
- Providers may also be paid by fee-for-service. This means they get a Plan-agreed-upon fee for each service they provide.

You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members.

If you have ideas, tell us about them. Maybe you’d like to work with one of our member advisory boards or committees. Call Member Services at 1-866-463-6743 to find out how you can help.

Information from Member Services

Here is information you can get by calling Member Services or by accessing our website at healthfirst.org:

- A list of names, addresses, and titles of Healthfirst’s Board of Directors, Officers, Controlling Parties, Owners, and Partners
- A copy of the most recent financial statements/balance sheets, summaries of income and expenses
- A copy of the most recent individual direct pay subscriber contract
- Information from the Department of Financial Services about consumer complaints about Healthfirst
- How we keep your medical records and member information private
- In writing, we will tell you how Healthfirst checks on the quality of care to our members
We will tell you which hospitals our health providers work with.
If you ask us in writing, we will tell you the guidelines we use to review conditions or diseases that are covered by Healthfirst.
If you ask in writing, we will tell you the qualifications needed and how healthcare providers can apply to be part of Healthfirst.
If you ask, we will tell you:
1) whether our contracts or subcontracts include physician incentive plans that affect the use of referral services and, if so
2) information on the type of incentive arrangements used; and
3) whether stop-loss protection is provided for physicians and physician groups.
Information about how our company is organized and how it works.

Keep Us Informed
If you enrolled through the New York State of Health (NYSOH), call them at 1-855-355-5777 whenever these changes happen in your life:

- You change your name, address, or telephone number
- You have a change in Medicaid eligibility
- You are pregnant
- You give birth
- There is a change in insurance for you or your children

After you have contacted NYSOH, call Member Services at 1-866-463-6743 to make sure we are aware of the changes. If you no longer qualify for Medicaid, call Member Services to see if you are eligible for another program, or you can check with your local Department of Social Services.

Disenrollment and Transfers

1. If YOU want to leave Healthfirst

You can try us out for 90 days. You may leave Healthfirst and join another health plan at any time during that time. If you do not leave in the first 90 days, however, you must stay in Healthfirst for nine more months, unless you have a good reason (good cause) for leaving.

Some examples of good cause include:

- Our health plan does not meet New York State requirements and members are harmed because of it
- You move out of our service area
- You, the plan, and the LDSS all agree that disenrollment is best for you
- You are or become exempt or excluded from managed care
- We do not offer a Medicaid managed care service that you can get from another health plan in your area
- You need a service that is related to a benefit we have chosen not to cover and getting the service separately would put your health at risk
- We have not been able to provide services to you as we are required to under our contract with the State
- We do not contract with Federally Qualified Health Centers (FQHCs) and you want to get your care from a FQHC

To change plans:

- Call the Managed Care staff at your local Department of Social Services
- If you live in one of the five boroughs of NYC or on Long Island, call New York Medicaid Choice at 1-800-505-5678. The New York Medicaid Choice counselors can help you change health plans

You may be able to transfer to another plan over the phone. If you have to be in managed care, you will have to choose another health plan.

It may take between two and six weeks to process, depending on when your request is received. You will get a notice that the change will take place by a certain date. Healthfirst will provide the care you need until then.

You can ask for faster action if you believe the timing of the regular process will cause added damage to your health. You can also ask for faster action if you have complained because you did not agree to the enrollment. Just call your local Department of Social Services or New York Medicaid Choice.
2. You Could Become Ineligible for Medicaid Managed Care

- You or your child may have to leave Healthfirst if you or the child:
  - move out of the county or service area
  - change to another managed care plan
  - join an HMO or other insurance plan through work
  - go to prison
  - otherwise lose eligibility
- Your child may have to leave Healthfirst or change plans* if he or she:
  - joins a Physically Handicapped Children’s Program, or
  - is placed in foster care by an agency that has a contract to provide managed care services for all children in foster care in New York City, or
* is placed in foster care by the local Department of Social Services in an area that is not served by your child’s current plan.

- If you have to leave Healthfirst or become ineligible for Medicaid, all of your services may stop unexpectedly, including any care you receive at home. Call New York Medicaid Choice at 1-800-505-5678 right away if this happens.

3. We Can Ask You to Leave Healthfirst

You can also lose your Healthfirst membership if you often:
- refuse to work with your PCP in regard to your care,
- don’t keep appointments,
- go to the emergency room for non-emergency care,
- don’t follow Healthfirst’s rules,
- do not fill out forms honestly or do not give true information (commit fraud),
- cause abuse or harm to plan members, providers, or staff, or
- act in ways that make it hard for us to do our best for you and other members even after we have tried to fix the problems.

Plan Appeals

There are some treatments and services that you need to get approval for 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 decision about your care, there are steps you can take.

Your provider can ask for reconsideration
If we made a decision that your service authorization request was not medically necessary or was experimental or investigational and we did not talk to your doctor about it, 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 think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a Plan Appeal.

- You have 60 calendar days from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services at 1-866-463-6743 if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.
Aid to continue while appealing a decision about your care:

If we decided to reduce, suspend, or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided.

You must ask for your Plan Appeal:

- Within ten days from being told that your care is changing; or
- By the date the change in services is scheduled to occur, whichever is later

If your Plan Appeal results in another denial, you may have to pay for the cost of any continued benefits that you received.

You can call or write to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the service
- Any specific information we said we needed in the Initial Adverse Determination notice

To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records, and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review.

You can ask to see these documents or ask for a free copy by calling 1-866-463-6743

Give us your information and materials by phone or mail:

- Phone:
  Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm

- Mail:
  Healthfirst
  P.O. Box 5166
  New York, NY 10274-5166
  Attention: Appeals and Grievances Department

If you ask for a Plan Appeal by phone, unless it is fast tracked, you must also send your Plan Appeal to us in writing. After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

If you are asking for an out-of-network service or provider:

- If we said that the service you asked for is not very different from a service available from a participating provider, you can ask us to check if this service is medically necessary for you. You will need to ask your doctor to send this information with your Plan Appeal:
  1) a statement in writing from your doctor that the out-of-network service is very different from the service the plan can provide from a participating provider.
  Your doctor must be a board-certified or board-eligible specialist who treats people who need the service you are asking for
  2) two medical or scientific documents that prove the service you are asking for is more helpful to you and will not cause you more harm than the service the plan can provide from a participating provider

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

- If you think our participating provider does not have the correct training or experience to provide a service, you can ask us to check if it is medically necessary for you to be referred to an out-of-network provider. You will need to ask your doctor to send this information with your appeal:
  1) a statement in writing that says our participating provider does not have the correct training and experience to meet your needs, and
2) that recommends an out of network provider with the correct training and experience who is able to provide the service

Your doctor must be a board certified or board eligible specialist who treats people who need the service you are asking for.

If your doctor does not send this information, we will still review your Plan Appeal. However, you may not be eligible for an External Appeal. See the External Appeal section later in this handbook.

What happens after we get your Plan Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Plan Appeal.
- We will send you a free copy of the medical records and any other information 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.
- You can also provide information to be used in making the decision in person or in writing. Call Healthfirst Member Services at 1-866-463-6743 if you are not sure what information to give us.
- Plan Appeals of clinical matters will be decided by qualified healthcare 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 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 the 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 may file a complaint with the New York State Department of Health at 1-800-206-8125.

Timeframes for Plan Appeals

- **Standard Plan Appeals**: If we have all the information we need, we will tell you our decision within 30 calendar days from when you asked for your Plan Appeal.
- **Fast-track plan appeals**: If we have all the information we need, fast-track Plan Appeal decisions will be made in two working 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.
  - If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will make a decision about your appeal within 24 hours.
  - We will tell you our decision by phone and send a written notice later.

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 Plan Appeal will be reviewed under the standard process; or
- 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; or
- If your request was denied when you asked for home health care after you were in the hospital; or
- If your request was denied when you asked for more inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital.

If we need more information to make either a standard or fast-track decision about your Plan Appeal, we will:

- Write you 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 no later than 14 days from the day we asked for more information

You or your representative 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 or writing to Member Services.

You or your representative can file a complaint with the plan if you don’t agree with our decision to take more time to review your Plan 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 1-800-206-8125.

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 the Fair Hearing section of this handbook.

If we do not decide your Plan Appeal on time, and we said the service you are asking for is:

1) not medically necessary;
2) experimental or investigational;
3) not different from care you can get in the plan’s network; or
4) 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

You have other appeal rights if we said the service you are asking for was:

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

For these types of decisions, 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, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal.

Before you ask for an External Appeal:

1) You must file a Plan Appeal 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 External 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 four 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 four months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to: New York State Department of Financial Services, 99 Washington Avenue, Box 177, Albany, NY 12210. You can call Member Services at 1-866-463-6743 if you need help filing an appeal.

Your External Appeal will be decided in 30 days. More time (up to five workdays) 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, or
- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited external appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:

- you ask for a fast-track internal appeal within 24 hours, and
- you ask for a fast-track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast-track Plan Appeal in 24 hours. The fast-track External Appeal will be decided in 72 hours.

The External Appeal 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. You may ask for a Fair Hearing or ask for an 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 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 with or leaving Healthfirst
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor’s decision stops or limits your Medicaid benefits. You must file a complaint with Healthfirst. If Healthfirst agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will have 120 calendar days from the date of the Final Adverse Determination to ask for a state 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; or
  - did not let you dispute a copay amount, other amount you owe, or payment you made for your healthcare.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

**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 you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.**

- 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.

The decision you receive from the fair hearing officer will be final.
You can use one of the following ways to request a Fair Hearing:

1. By phone – call 1-800-342-3334
2. By fax – 1-518-473-6735
3. Online – otda.state.ny.gov/oah/FHReq.asp
4. By mail – NYS Office of Temporary and Disability Assistance, Office of Administrative Hearings, Managed Care Hearing Unit, P.O. Box 22023, Albany, New York 12201-2023

When you ask for a Fair Hearing about a decision Healthfirst made, we must send you a copy of the evidence packet. This is 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 your hearing, you can call 1-866-463-6743 to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling 1-800-206-8125.

Complaint Process

Complaints

We hope our health plan serves you well. If you have a problem, talk with your PCP, or call or write Member Services. Most problems can be solved right away. If you have a problem or dispute with your care or services, you can file a complaint with the plan. Problems that are not solved right away over the phone, and any complaint that comes in the mail, will be handled according to our complaint procedure described below.

You can call Member Services at 1-866-463-6743 if you need help filing a complaint, or following the steps of the complaint process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.

We will not make things hard for you or take any action against you for filing a complaint.

You also have the right to contact the New York State Department of Health about your complaint at 1-800-206-8125, or write to: Complaint Unit, Bureau of Consumer Services, OHIP DHPCO 1CP-1609, New York State Department of Health, Albany, New York 12237.

You may also contact your local Department of Social Services with your complaint at any time. You may call the New York State Department of Financial Services at 1-800-342-3736 if your complaint involves a billing problem.

How to File a Complaint with Our Plan

You can file a complaint, or you can have someone else, like a family member, friend, doctor or lawyer, file the complaint for you. You and that person will need to sign and date a statement saying you want that person to represent you.

To file by phone, call our Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 8am–6pm. If you call us after hours, leave a message. We will call you back the next workday. 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
P.O. Box 5166
New York, NY 10274-5166
Attention: Appeals and Grievances Department

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 workdays. The letter will tell you:

■ Who is working on your complaint
■ How to contact this person
■ If we need more information

You can also provide information to be used reviewing your complaint in person or in writing. Call Healthfirst at 1-866-463-6743 if you are not sure what information to give us.

Your complaint will be reviewed by one or more qualified people. If your complaint involves clinical matters, your case will be reviewed by one or more qualified healthcare professionals.
After we review your complaint

- We will let you know our decision within 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 within 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 seven 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 three workdays.

- 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 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 workdays 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 a complaint 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 workdays. 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.

If we have all the information we need, you will know our decision in 30 workdays. If a delay would risk your health, you will get our decision within two workdays 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 1-800-206-8125.

Member Rights and Responsibilities

Your Rights

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

- Be cared for with respect, without regard for health status, sex, race, color, religion, national origin, age, marital status, or sexual orientation
- Be told where, when, and how to get the services you need from Healthfirst
- Be told by your PCP what is wrong, what can be done for you, and what will likely be the result in language you understand
- Get a second opinion about your care
- Give your OK to any treatment or plan for your care after that plan has been fully explained to you
- Refuse care and be told what you may risk if you do
- Get a copy of your medical record, and talk about it with your PCP, and to ask, if needed, that your medical record be amended or corrected
- Be sure that your medical record is private and will not be shared with anyone except as required by law, contract, or with your approval
- Use the Healthfirst complaint system to settle any complaints, or you can complain to the New York State Department of Health or the local Department of Social Services any time you feel you were not fairly treated.

- Use the State Fair Hearing system.

- Appoint someone (relative, friend, lawyer, etc.) to speak for you if you are unable to speak for yourself about your care and treatment.

- Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.

**Your Responsibilities**

As a member of Healthfirst, you agree to:

- Work with your PCP to guard and improve your health.

- Find out how your healthcare system works.

- Listen to your PCP’s advice and ask questions when you are in doubt.

- Call or go back to your PCP if you do not get better, or ask for a second opinion.

- Treat healthcare staff with the respect you expect yourself.

- Tell us if you have problems with any healthcare staff. Call Member Services.

- Keep your appointments. If you must cancel, call as soon as you can.

- Use the emergency room only for real emergencies.

- Call your PCP when you need medical care, even if it is after hours.

**Advance Directives**

There may come a time when you can’t decide about your own healthcare. By planning in advance, you can arrange now for your wishes to be carried out. First, let family, friends, and your doctor know what kinds of treatment you do or don’t want. Second, you can appoint an adult you trust to make decisions for you. Be sure to talk with your PCP, your family, or others close to you so they will know what you want. Third, it is best if you put your thoughts in writing. The documents listed below can help. You do not have to use a lawyer, but you may wish to speak with one about this. You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality healthcare benefits. The only purpose is to let others know what you want if you can’t speak for yourself.

**Healthcare Proxy** — With this document, you name another adult that you trust (usually a friend or family member) to decide about medical care for you if you are not able to do so. If you do this, you should talk with the person so they know what you want.

**CPR and DNR** — You have the right to decide if you want any special or emergency treatment to restart your heart or lungs if your breathing or circulation stops. If you do not want special treatment, including cardiopulmonary resuscitation (CPR), you should make your wishes known in writing. Your PCP will provide a DNR (Do Not Resuscitate) order for your medical records. You can also get a DNR form to carry with you and/or a bracelet to wear that will let any emergency medical provider know about your wishes.

**Organ Donor Card** — This wallet-sized card says that you are willing to donate parts of your body to help others when you die. Also, check the back of your driver’s license to let others know if and how you want to donate your organs.
Notice of Privacy Practices
(“Privacy Notice”)

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE DESCRIBES HOW HEALTH 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, 2019.

At Healthfirst (made up of Healthfirst, Inc., Healthfirst PHSP, Inc., Healthfirst Health Plan, Inc., and Healthfirst Insurance Company, Inc. (HFIC), 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 with 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 member and how you can exercise those rights. Healthfirst is making this notice available 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 Healthfirst Insurance Company, Inc. (HFIC). 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 this notice and within 60 days of the change will provide a new Privacy Notice to all persons to whom we are required to give the new notice. 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 OHCA 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 for any other joint healthcare 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, BronxCare Health System, NYC Health + Hospitals, The Brooklyn Hospital Center, Northwell Health, NYU Langone 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.
Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

– You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

– We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

– You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

– We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

– You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

– We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

– You can ask us not to use or share certain health information for treatment, payment, or our operations.

– We are not required to agree to your request, and we may say “no” if it would affect your care. However, if you tell us you would be in danger if we did not say yes, then we must agree to your request.

Get a list of those with whom we’ve shared information

– You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

– We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make).

– We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

– If you have given someone health care proxy or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

– If you have given someone power of attorney, that person can exercise your rights and make choices about your premium billing and claims out of pocket expenses.

– We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

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:
How do we typically use or share your health information?

We typically use or share your health information in the following ways:

**Help manage the healthcare treatment you receive**

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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.

**Run our organization**

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

**Help with public health and safety issues**

We can share health information about you for certain situations such as

- preventing disease.

- helping with product recalls.

- reporting adverse reactions to medications.

- reporting suspected abuse, neglect, or domestic violence.

- preventing or reducing a serious threat to anyone’s health or safety.
Do research

We can use your information in certain research activities. We will be sure to get your permission where required.

Comply with the 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.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

– We can share health information about you with organ procurement organizations.

– We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers’ compensation, law enforcement, and other government requests

We can use or share health information about you

– for workers’ compensation claims.

– for law enforcement purposes or with a law enforcement official.

– with health oversight agencies for activities authorized by law.

– for special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to

– share information with your family, close friends, or others involved in payment for your care.

– share information in a disaster relief situation.

If you are not able to tell us your preference—for example if you are unconscious—we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

– We will never share your information for marketing purposes without your written permission.

– We will never sell your information.

Our Responsibilities

– We are required by law to maintain the privacy and security of your protected health information.

– We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

– We will never share any of your Substance User Disorder (SUD) information without your permission.

– We must follow the duties and privacy practices described in this notice and give you a copy of it.
We must comply with additional New York State laws that have a higher level of protection for personal information, particularly information relating to HIV/AIDS status or treatment; mental health; substance use disorder; and family planning.

Collecting, Sharing, and Safeguarding Your Financial Information

In addition to health information, Healthfirst may collect other information about you and your dependents (referred to as personally identifiable information, or PII) in the normal course of business in order to provide healthcare service to you, such as

- 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 healthcare providers, or others, including, but not limited to, appeals and grievance information, claims for benefits, premium payment history, and coordination of benefits information. This also includes information regarding your health benefits, and health risk assessments.

- **How Your PII is Used or Disclosed with Third Parties**

We do not disclose your PII to anyone without your written authorization, except as permitted by law (i.e., authorizing requests for healthcare 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 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 (also referred to as “opting out”). 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.

We restrict access to your PII 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 PII. Employees who violate our confidentiality or security policies are subject to disciplinary action, up to and including termination of employment.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our website, and we will mail a copy to you.
Notice of Non-Discrimination

Healthfirst complies with Federal civil rights laws. Healthfirst does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Healthfirst provides the following:

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

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

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

- Mail: Healthfirst Member Services, P.O. Box 5165, New York, NY, 10274-5165
- Phone: 1-866-305-0408 (for TTY services, call 1-888-542-3821)
- Fax: 1-212-801-3250
- In person: 100 Church Street, New York, NY 10007
- Email: http://healthfirst.org/members/contact/

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

- Web: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY 800-537-7697)
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-305-0408 (TTY 1-888-542-3821).</td>
</tr>
<tr>
<td>Yiddish</td>
<td>אױפערדייזן: אָיוַן אַ ראָד אַ יידיש,תעכּן פּאָראַמֶן פּאַר אַהֲרוֹן טֶרֶקְשאָế טֶרֶהוֹטֶס פּאַר אָהֲרוֹן טֶרֶקְשאָה פּאַר אַהֲרוֹן טֶרֶקְשאָה פּאַר אָהֲרוֹן טֶרֶקְשאָה (TTY: 1-888-542-3821) 1-866-305-0408</td>
</tr>
<tr>
<td>Urdu</td>
<td>خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY: 1-888-542-3821) 1-866-305-0408</td>
</tr>
</tbody>
</table>
## Community Offices Near You

### BRONX

**East Tremont**

**774 E. Tremont Avenue**
(between Prospect and Marmion Avenues)

**Fordham**

**412 E. Fordham Road**
(entrance on Webster Avenue)

### BROOKLYN

**Bensonhurst**

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

**Flatbush**

**2166 Nostrand Avenue**
(between Avenue H and Hillel Place)

**Sunset Park**

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

### MANHATTAN

**Chinatown**

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

**28 E. Broadway**
(between Catherine and Market Streets)

**Harlem**

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

**Washington Heights**

**1467 St. Nicholas Avenue**
(between W. 183rd and W. 184th Streets)

### QUEENS

**Elmhurst**

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

**Flushing**

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

**Main Plaza Mall**

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

**Jackson Heights**

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

**Jamaica**

**Jamaica Colosseum Mall**
**89-02 165th Street, Main Level**
(between 89th and Jamaica Avenues)

**Richmond Hill**

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

### LONG ISLAND (continued)

**SUFFOLK COUNTY**

**Bay Shore**

**Westfield South Shore Mall**
**1701 Sunrise Highway**
(in the JCPenney Wing)

**Lake Grove**

**Smith Haven Mall**
**313 Smith Haven Mall**
(in the Sears Wing)

**Patchogue**

**99 West Main Street**
(between West and Havens Avenues)

**Shirley**

**La Placita**
**58 D Surrey Circle**
(between William Floyd Parkway and Floyd Road)

### WESTCHESTER COUNTY

**Yonkers**

**13 Main Street**
(between Warburton Avenue and N Broadway)

### ORANGE COUNTY

**Middletown**

**Galleria at Crystal Run**
**1 Galleria Drive, Lower Level**
(in the Macy’s Wing)

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Community office locations subject to change. For the most up-to-date locations, please visit [healthfirst.org/locations](http://healthfirst.org/locations).
For questions about Medicaid benefits, call Member Services at 1-866-463-6743 (TTY 1-888-542-3821), Monday to Friday, 9am–6pm. To access your secure Healthfirst account, visit us at MyHFNY.org. We’re mobile-optimized, so you can use your smartphone or any mobile device!

Coverage is provided by Healthfirst Health Plan, Inc., Healthfirst PHSP, Inc., and/or Healthfirst Insurance Company, Inc. (together, “Healthfirst”). Plans contain exclusions and limitations. This handbook is available in English, Spanish, and Chinese. Este manual está disponible en inglés, español y chino. 本手冊可用英文、西班牙文與中文提供。