Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)

Member Handbook

April 1, 2014 – December 31, 2014

Your Health and Drug Coverage under Health Net Cal MediConnect

This handbook tells you about your coverage under Health Net Cal MediConnect through December 31, 2014. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Long-term services and supports consist of Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Nursing Facilities (NF).

This is an important legal document. Please keep it in a safe place.

This Cal MediConnect plan is offered by Health Net Community Solutions, Inc. When this *Member Handbook* says “we,” “us,” or “our,” it means Health Net Community Solutions, Inc. When it says “the plan” or “our plan,” it means Health Net Cal MediConnect (Medicare-Medicaid Plan).

You can get this handbook for free in other languages. Call 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. The call is free.

លោកអ្នកអាចទទួលបានសៀវភៅណែនាំនេះ ដោយឥតគិតថ្លៃ ជាភាសាផ្សេងទៀត ។ សូមទូរស័ព្ទមកលេខ 1-855-464-3571 (TTY: 711), 24ម៉ោងក្នុងមួយថ្ងៃ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ ។ ការហៅទូរស័ព្ទគឺឥតគិតថ្លៃ ។

您可以免費獲得本手冊的其他語言版本。請致電 1-855-464-3571 (TTY: 711)，每天 24 小時，每週 7 天均提供服務。此為免費電話。

본 정보를 무료로 다른 언어로 받으실 수 있습니다. 연중무휴 24 시간 운영되는 1-855-464-3571 (TTY: 711)번으로 전화해 주십시오. 통화는 무료입니다.

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If you have questions, please call Health Net Cal MediConnect at1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. The call is free. **For more information**, visit www.healthnet.com/calmediconnect.

Этот справочник вы можете получить бесплатно в переводе на другие языки. Позвоните по телефону1-855-464-3571 (TTY: 711); линия работает круглосуточно и без выходных. Звонки бесплатные.

Puede obtener este manual en otros idiomas en forma gratuita. Llame a 1-855-464-3571 (TTY: 711), las 24 horas del día, los 7 días de la semana. La llamada es gratuita.

Maaari ninyong makuha ang handbook na ito nang libre sa ibang mga wika. Tawagan ang 1-855-464-3571 (TTY: 711), 24 oras sa isang araw, pitong araw sa isang linggo. Libre ang pagtawag.

Quý vị có thể nhận miễn phí sổ tay này bằng các ngôn ngữ khác. Hãy gọi 1-855-464-3571 (TTY: 711), 24 giờ một ngày, bảy ngày một tuần. Cuộc gọi này miễn phí.

شما می توانید این دفترچه را به طور رایگان به سایر زبان ها دریافت کنید. در 24 ساعت شبانروز و هفت روز هفته با کانتی لُس آنجلس به شماره: 1-855-464-3571 تماس بگیرید (TTY: 711). این تماس رایگان است.

You can ask for this handbook in other formats, such as Braille or large print. Call 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

Disclaimers

Health Net Community Solutions, Inc. is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

Limitations, copays, and restrictions may apply. For more information, call Health Net Cal MediConnect Member Services or read the Health Net Cal MediConnect Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Health Net Cal MediConnect pay for your services.

Benefits, List of Covered Drugs, pharmacy and provider networks and/or co-payments may change from time to time throughout the year and on January 1 of each year.

Copays for prescription drugs may vary based on the level of Extra Help you receive. Please contact the plan for more details.

Chapter 1: Getting started as a member

Table of Contents

A. Welcome to Health Net Cal MediConnect

Health Net Cal MediConnect is a Cal MediConnect plan. A Cal MediConnect plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Health Net Cal MediConnect was approved by California and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Cal MediConnect.

Cal MediConnect is a demonstration program jointly monitored by California and the federal government to provide better care for people who have both Medicare and Medi-Cal. Under this demonstration, the state and federal government want to test new ways to improve how you receive your Medicare and Medi-Cal services.

The Health Net difference

You want a health plan you can count on. That's where Health Net comes in.

Experience you can count on

Health Net helps more than a million people on Medicare and Medi-Cal get the services they need. We do this by offering better access to your Medicare and Medi-Cal benefits and services, plus a whole lot more:

- We've been building high-quality networks of doctors for more than 20 years. A network is a team of health care Providers contracted with a Health Plan to provide services. The health care Providers may be contracted directly with the Health Plan or through a Medical Group. A Medical Group is a group of PCPs (Primary Care Physicians), Specialists and other health care Providers that work together. These networks help individuals with Medicare and Medi-Cal get the care they need. We work hard to grow these networks to cover more people in more locations.
- Award-winning Cultural and Linguistic program – Health Net is the only Cal MediConnect plan to receive the *Multicultural Health Care Distinction* from the National Committee for Quality Assurance. This means that no matter where you are from or what language you speak, Health Net will make sure you get quality health care that is fair and easy to understand.
- We're here for your whole family – We offer plans and services that cover individuals and families, through every stage of their lives and health.
- Your community is our community – We're a Southern California company, so our employees live where you live. We support our local communities with:
  - Health screenings at local health events and community centers

– No-cost health education classes

B. What are Medicare and Medi-Cal?

Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, and
- People with end-stage renal disease (kidney failure).

Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare.

Medicare and California approved Health Net Cal MediConnect. You can get Medicare and Medi-Cal services through our plan as long as:

- We choose to offer the plan, and
- Medicare and California allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medi-Cal services would not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medi-Cal services from Health Net Cal MediConnect, including prescription drugs. You will not pay extra to join this health plan.

Health Net Cal MediConnect will help make your Medicare and Medi-Cal benefits work better together and work better for you. Some of the advantages include:

- You will have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You will have access to a care coordinator. This is a person who works with you, with Health Net Cal MediConnect, and with your care team to help make a care plan.
- You will be able to direct your own care with help from your care team and care coordinator.

- The care team and care coordinator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will help coordinate the services you need. This means, for example:
  - » Your care team will make sure your doctors know about all the medicines you take so they can make sure you are taking the right medicines, and so your doctors can reduce any side effects you may have from the medicines.
  - » Your care team will make sure your test results are shared with all your doctors and other providers, as appropriate.

D. What is Health Net Cal MediConnect's service area?

Our service area includes all parts of Los Angeles County with the exception of the following ZIP code: 90704.

Only people who live in our service area can join Health Net Cal MediConnect.

If you move outside of our service area, you cannot stay in this plan. You will need to contact your local county eligibility worker:

CALL	Local Toll-Free: 1-877-597-4777 Statewide Toll-Free: 1-800-541-5555 This call is free. Monday-Friday, 8 a.m. to 5 p.m., except holidays
TTY	*Local Toll-Free:* 1-800-660-4026 *Statewide TTY:* 711 (National Relay Services) This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Refer to the White Pages under COUNTY GOVERNMENT of your phone book for the nearest social services office.
WEBSITE	http://dpss.lacounty.gov/programs.cfm

E. What makes you eligible to be a plan member?

You are eligible for our plan as long as you:

- Live in our service area, ***and***
- Are age 21 and older at the time of enrollment, ***and***
- Have both Medicare Part A and Medicare Part B, ***and***

Are currently eligible for Medi-Cal and receiving full Medi-Cal benefits, including;

- Individuals enrolled in the Multipurpose Senior Services Program (MSSP).
- Individuals who meet the share of cost provisions described below:
    - Nursing facility residents with a share of cost,
    - MSSP enrollees with a share of cost, and
    - IHSS recipients who met their share of cost on the first day of the month in the fifth and fourth months prior to their effective passive enrollment date for the Demonstration.

There may be additional eligibility rules in your county. Call Member Services for more information.

F. What to expect when you first join a health plan

When you first join the plan, you will receive a Health Risk Assessment (HRA) within the first 90 days (some high-risk individuals will receive an HRA within 45 days).

We are required to complete an HRA for you. This HRA is the basis for developing your Individual Care Plan (ICP). The HRA will include questions to identify your medical, long-term services and supports (LTSS), and behavioral health and functional needs.

We will reach out to you to complete the HRA. The HRA can be completed by an in-person visit, telephone call, or mail.

We will send you more information regarding this HRA.

If Health Net Cal MediConnect is new for you, you can keep seeing the doctors you go to now for a certain amount of time. You can keep your current providers and service authorizations at the time you enroll for up to 6 months for Medicare services and up to 12 months for Medi-Cal services if all of the following criteria are met:

- You, your representative, or your provider makes a direct request to us to continue to see your current provider.

- We are required to approve this request if you can show an existing relationship with a primary or specialty care provider, with some exceptions.
- We will determine a pre-existing relationship by reviewing your health information available to us. You may also give us information to show this pre-existing relationship with a provider.
- An existing relationship means you saw an out-of-network primary care provider at least once or specialty care provider at least twice for a non-emergency visit during the 12 months prior to the date of your initial enrollment in Health Net Cal MediConnect.
- We have 30 days to respond to your request. You may also ask us to make a faster decision and we must respond in 15 days.
- When making a request to continue care with your current provider, you or your provider must show documentation of an existing relationship and agree to certain terms.
- This request **cannot** be made for providers of durable medical equipment (DME), transportation, other ancillary services, or services not included under Cal MediConnect.

After the continuity of care period ends, you will need to see doctors and other providers in the Health Net Cal MediConnect network unless we make an agreement with your out-of-network doctor. *A network provider is a provider who works with the health plan.* See Chapter 3 for more information on getting care.

G. What is a care plan?

A *care plan* is the plan for what health and behavioral services and long-term services and supports you need and how you will get them.

After your health risk assessment, your care team will meet with you to talk about what services you need and those to consider. Together, you and your care team will make a care plan.

At least every year, your care team will work with you to update your care plan.

H. Does Health Net Cal MediConnect have a monthly plan premium?

No.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, or call 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for the months you are enrolled in Health Net Cal MediConnect between April 1, 2014 and December 31, 2014.

J. What other information will you get from us?

You should have already received a Health Net Cal MediConnect member ID card, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your Health Net Cal MediConnect member ID card

Under our plan, you will have one card for your Medicare and Medi-Cal services, including long-term services and supports, certain behavioral health services, and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:

If your Cal MediConnect card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. You can call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medi-Cal card to get Cal MediConnect services. Keep those cards in a safe place, in case you need them later.

➔ Please remember, for the specialty mental health services that you may receive from the county mental health plan (MHP), you will need your Medi-Cal card to access those services.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Health Net Cal MediConnect network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 7).

➔ You can request an annual *Provider and Pharmacy Directory* by calling Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

You can also see the *Provider and Pharmacy Directory* at www.healthnet.com/calmediconnect, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are "network providers"?

- Network providers are doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities, and other places that provide health services in our plan. They also include long-term services and supports, behavioral health services, home health agencies, medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.
- Network providers have agreed to accept payment from our plan for covered services as payment in full.
- In-Home Supportive Services (IHSS) providers are not part of a network. You will always be able to select any IHSS provider.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week for more information or to get a copy of the *Provider and Pharmacy Directory.* You can also see the *Provider and Pharmacy Directory* at www.healthnet.com/calmediconnect, or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Health Net Cal MediConnect.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit www.healthnet.com/calmediconnect or call 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (*EOB*).

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

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number.
- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation.
- If you have any liability claims, such as claims from an automobile accident.
- If you are admitted to a nursing home or hospital.
- If you get care in a hospital or emergency room.
- If your caregiver or anyone responsible for you changes.
- If you are part of a clinical research study.

If any information changes, please let us know by calling Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

You may also change your address and/or phone number by visiting our website at www.healthnet.com/calmediconnect.

Do we keep your personal health information private?

Yes. State and federal laws require that we keep your medical records and personal health information private. We protect your health information. For more details about how we protect your personal health information, see Chapter 11.

Chapter 2: Important phone numbers and resources

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A. How to contact Health Net Cal MediConnect (Medicare-Medicaid) Member Services

CALL	1-855-464-3571 This call is free. 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 (National Relay Service) This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, seven days a week
WRITE	Health Net Cal MediConnect PO Box 10422 Van Nuys, CA 91410-0422
WEBSITE	www.healthnet.com/calmediconnect

Contact Member Services about:

- **Questions about the plan**
- **Questions about claims, billing or member cards**
- **Coverage decisions about your health care**

  A coverage decision about your health care is a decision about:

  » Your benefits and covered services, ***or***

  » The amount we will pay for your health services.

  Call us if you have questions about a coverage decision about your health care.

  ➔ To learn more about coverage decisions, see Chapter 9.

- **Appeals about your health care**

  An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

➔ To learn more about making an appeal, see Chapter 9.

- **Complaints about your health care**

  You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F below).

  ➔ You can call us and explain your complaint. Call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

  ➔ If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).

  ➔ You can send a complaint about Health Net Cal MediConnect to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

  ➔ You can make a complaint about Health Net Cal MediConnect to the Cal MediConnect Ombuds Program by calling 1-855-501-3077.

  ➔ To learn more about making a complaint about your health care, see Chapter 9.

- **Coverage decisions about your drugs**

  A coverage decision about your drugs is a decision about:

  » Your benefits and covered drugs, ***or***

  » The amount we will pay for your drugs.

  This applies to your Part D drugs, Medi-Cal prescription drugs, and Medi-Cal over-the-counter drugs.

  ➔ For more on coverage decisions about your prescription drugs, see Chapter 9.

- **Appeals about your drugs**

  An *appeal* is a way to ask us to change a coverage decision.

  For more information on how to make an appeal about your prescription drugs over the phone, please contact Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. Member Services is available 24 hours a day, seven days a week.

  ➔ For more on making an appeal about your prescription drugs, see Chapter 9.

- **Complaints about your drugs**

You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. *(See the section above.)*

You can send a complaint about Health Net Cal MediConnect to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

➔ For more on making a complaint about your prescription drugs, see Chapter 9.

- **Payment for health care or drugs you already paid for**

➔ For more on how to ask us to pay you back, or to pay a bill you have received, see Chapter 7.

➔ If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9 for more on appeals.

B. How to contact your Care Coordinator

A care coordinator is one main person who works with you, with the health plan, and with your care providers to make sure you get the health care you need. A care coordinator will be assigned to you when you become a plan member.

The care coordinator will give you his/her phone number the first time you talk. A care coordinator helps put together healthcare services to meet your healthcare needs. He/she works with you to make your care plan. He/She helps you decide who will be on your care team. Your care coordinator gives you information you need to manage your healthcare. This will also help you make choices that are right for you. You can find out who your care coordinator is by calling Member Services.

If you would like to change your care coordinator or have any additional questions, please contact the phone number listed below.

CALL	1-855-464-3571 This call is free. 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 (National Relay Service) This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, seven days a week
WRITE	Your Care Coordinator will provide this information to you.

Contact your care coordinator about:

- **Questions about your health care**
- **Questions about getting behavioral health (mental health and substance use disorder) services**
- **Questions about transportation**
- **Questions about long-term services and supports (LTSS):** LTSS include In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Service Programs (MSSP), and Nursing Facilities (NF).

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

» In-Home Supportive Services (IHSS),
» Community-Based Adult Services (CBAS),
» Multipurpose Senior Service Programs (MSSP),
» Skilled nursing care,
» Physical therapy,
» Occupational therapy,
» Speech therapy,
» Medical social services, and
» Home health care.

LTSS Eligibility Requirements:

In-Home Supportive Services (IHSS): To qualify for enrollment in the In-Home Supportive Services (IHSS) program, Medi-Cal members must meet all of the following criteria:

- Be a resident of California and United States citizen and live in their own home
- Be age 65 or older, legally blind or disabled
- Be a current Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipient or be eligible to receive SSI/SSP
- Be able to obtain a Health Care Certification form (SOC 873) from a licensed health care professional that indicates the inability to independently perform some activity of daily living, and that without IHSS, the member would be at risk of placement in out-of-home care

Community-Based Adult Services (CBAS):

Medi-Cal members who have a physical, mental or social impairment occurring after age 18, and who may benefit from community-based adult services (CBAS), may be eligible. Eligible members must meet one of the following criteria:

- Needs that are significant enough to meet nursing facility level of care A (NF-A) or above
- A moderate to severe cognitive disability, including moderate to severe Alzheimer's or other dementia
- A developmental disability
- A mild to moderate cognitive disability, including Alzheimer's or dementia and a need for assistance or supervision with two of the following:
    - Bathing
    - Dressing

  - Self-feeding
  - Toileting
  - Ambulation
  - Transferring
  - Medication management
  - Hygiene
- A chronic mental illness or brain injury and a need for assistance or supervision with two of the following:
  - Bathing
  - Dressing
  - Self-feeding
  - Toileting
  - Ambulation
  - Transferring
  - Medication management, or need assistance or supervision with one need from the above list and one of the following:
    - Hygiene
    - Money management
    - Accessing resources
    - Meal preparation
    - Transportation
- A reasonable expectation that preventive services will maintain or improve the present level of function (for example, in cases of brain injury due to trauma or infection)
- A high potential for further deterioration and probable institutionalization if CBAS is not available (for example, in cases of brain tumors or HIV-related dementia)

Multipurpose Senior Service Programs (MSSP):

To qualify for the Multipurpose Senior Services Program (MSSP), Medi-Cal members must meet all of the following criteria:

- Be age 65 or older
- Be certifiable for placement in a skilled nursing facility (SNF)
- Live in a county with an MSSP site and be within the site's service area
- Be appropriate for care management services
- Be able to be served within MSSP's cost limitations

Nursing Facilities (NF):

Members must require 24-hour short- or long-term medical care as prescribed by a physician to be eligible for Long-term care (LTC) or skilled nursing facility (SNF) placement.

C. How to contact the Nurse Advice Call Line

Nurse24 is a service that lets members talk with a licensed nurse any time of the day by phone or chat. With Nurse24, you get the convenience of a single point of contact for any and every health question, goal or situation. The clinician you talk to – a trained professional such as a nurse – will present choices, explain options and support you based on your individual values, family needs, situation and preferences.

CALL	1-800-893-5597 This call is free. 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	1-800-276-3821 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, seven days a week

Contact the Nurse Advice Call Line about:

- **Questions about your health care**
- One-on-one consultations with a trained clinician. All of our 24-hour clinicians have experience and know-how to help you with your primary concern while exploring and addressing the range of issues that may be related to and complicated by it.
- Answers to health questions 24 hours a day. However, always call 9-1-1 or go straight to the emergency room in a life-threatening situation.
- Techniques for talking to your doctor and evaluating treatment options.
- Pointers for setting achievable health goals on topics such as weight management, tobacco cessation, stress reduction, cholesterol management, blood pressure control and more.
- Guidance/support for living with an ongoing illness such as asthma, diabetes, heart disease and depression, among others.

- Specialized support for end-stage diseases, severe trauma — expert nurse case managers work one-on-one with patients and families, facilitating any and all services that may be helpful — home care, hospice, skilled nursing, behavioral health, and more.
- Doctor-patient connection. Doctors know medicine. You know your body. With our plan, it's easy to learn what questions to ask, how to explain your preferences and to get the support you need from your doctor. The more you know, the easier it is to navigate complicated health choices and make the ones that are right for you.

D. How to contact the Behavioral Health Crisis Line

CALL	1-855-464-3571 This call is free. 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 (National Relay Service) This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, seven days a week

Contact the Behavioral Health Crisis Line about:

- **Questions about behavioral health and substance abuse services**

Health Net Cal MediConnect provides you with around the clock access to medical information and advice. When you call, our behavioral health specialists will answer your wellness-related questions. If you have an urgent health need but it is not an emergency, you can call our Behavioral Health Crisis Line 24 hours a day, 7 days a week for behavioral health clinical questions.

For questions regarding your county specialty mental health services, go to page 30.

E. How to contact the Health Insurance Counseling and Advocacy Program (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) gives free health insurance counseling to people with Medicare. HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is not connected with any insurance company or health plan.

CALL	1-213-383-4519 Within L.A.County: 1-800-824-0780 Monday-Friday, 9:00 a.m. to 5:00 p.m.
WRITE	HICAP 520 S. Lafayette Park Place, Suite 214 Los Angeles, CA 90057
WEBSITE	http://css.lacounty.gov/health-insurance.aspx

Contact HICAP about:

- **Questions about your Cal MediConnect plan**

  HICAP counselors can:

  » Help you understand your rights,

  » Help you understand your plan choices,

  » Answer your questions about changing to a new plan,

  » Help you make complaints about your health care or treatment, ***and***

  » Help you straighten out problems with your bills.

F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called Livanta (California's Quality Improvement Organization). This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta (California's Quality Improvement Organization) is not connected with our plan.

CALL	1-877-588-1123
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	Appeals: 1-855-694-2929 All other reviews: 1-844-420-6672
WRITE	Livanta BFCC-QIO Program 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEBSITE	www.BFCCQIOAREA5.com

Contact Livanta (California's Quality Improvement Organization) about:

- **Questions about your health care**

  You can make a complaint about the care you have received if:

  » You have a problem with the quality of care,

  » You think your hospital stay is ending too soon, ***or***

  » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	http://www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Forms, Help & Resources” and then clicking on “Phone numbers & websites.” The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find health & drug plans.” If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Medi-Cal Health Care Options

Medi-Cal Health Care Options can help you if you have questions about selecting a Cal MediConnect plan or other enrollment issues. For free health insurance counseling for people with Medicare (HICAP), see Section E.

CALL	1-844-580-7272 Health Care Options representatives are available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	California Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	http://www.dhcs.ca.gov/services/Pages/NewHCOCall-inOptions.aspx

I. How to contact the Cal MediConnect Ombuds program

The Cal MediConnect Ombuds Program can help you with service or billing problems. They can answer your questions and help you understand what to do to handle your problem. The services are free.

The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan.

CALL	1-855-501-3077 This call is free. Monday-Friday, 8 a.m. to 5 p.m., except holidays This number will be available on April 1, 2014.
TTY	711 (National Relay Service) This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Cal MediConnect Ombudsman Consumer Center for Health Education & Advocacy 1764 San Diego Avenue, Suite 200 San Diego, CA 92110
WEBSITE	Please call the Cal MediConnect Ombuds Program at the phone number above.

J. How to contact County Social Services

If you need help with your In-Home Supportive Services (IHSS) benefits, contact your local county social services department.

The In-Home Supportive Services (IHSS) program provides in-home care to seniors and persons with disabilities (SPD), allowing them to remain safely in their homes with as much independence as possible. IHSS include, but are not limited to:

- Domestic and related services (housecleaning, meal preparation and clean up, laundry, and grocery shopping)
- Personal care services (bathing, dressing, grooming)
- Paramedical services (wound care, catheter care, injections)
- Family and caregiver training
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

Members who may benefit from IHSS are those with complex chronic medical, cognitive or psychological conditions and functional limitations who require regular health monitoring and social supports to maintain function in the community and prevent avoidable emergency department or hospital admissions, or short- or long-term nursing facility admission.

CALL	1-888-678-4477 This call is free. Monday-Friday, 8 a.m. to 5 p.m.
TTY	711 (National Relay Service) This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Refer to the White Pages under COUNTY GOVERNMENT of your phone book for the nearest social services office.
WEBSITE	http://dpss.lacounty.gov

K. How to contact your County Specialty Mental Health Plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet the medical necessity criteria.

CALL	Los Angeles County Department of Mental Health (DMH) Access Hotline: 1-800-854-7771 This call is free. 24 hours a day, seven days a week We have free interpreter services for people who do not speak English.
TTY	711 (National Relay Service) This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, seven days a week

Contact the county specialty mental health plan about:

- Questions about behavioral health services provided by the county

For free, confidential mental health information, referrals to service providers, and crisis counseling at any day or time, call the Los Angeles Department of Mental Health Access hotline.

L. How to contact the California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. The DMHC Help Center can help you with appeals and complaints against your health plan about Medi-Cal services

CALL	1-888-466-2219 DMHC representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday.
TTY	1-877-688-9891 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Help Center California Department of Managed Health Care 980 Ninth Street, Suite 500 Sacramento, CA 95814-2725
FAX	1-916-255-5241
WEBSITE	http://www.hmohelp.ca.gov

M.Other resources

Area Agencies on Aging

Your local Area Agency on Aging can provide you with information and help coordinate services available to older adults.

CALL	1-888-202-4248 1-213-738-2600
TTY	711 (National Relay Service)

WRITE	Los Angeles County Community & Senior Services 3333 Wilshire Blvd., 4th floor Los Angeles, CA 90010
WEBSITE	http://css.lacounty.gov/

Department of Health Care Services (DHCS)

As a member of our plan, you are eligible for both Medicare and Medi-Cal (Medicaid). Medi-Cal (Medicaid) is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. If you have questions about the assistance you get from Medi-Cal (Medicaid), contact the Department of Health Care Services (DHCS).

CALL	Toll free: 1-800-541-5555 1-916-449-5000
TTY	711 (National Relay Service)
WRITE	Department of Health Care Services PO Box 997413, MS 4400 Sacramento, CA 95899-7413
WEBSITE	www.medi-cal.ca.gov

Social Security

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

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

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

CALL	1-800-772-1213 Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	http://www.ssa.gov

Chapter 3: Using the plan's coverage for your health care and other covered services

Table of Contents

A. About "services," "covered services," "providers," and "network providers"

Services are health care, long-term services and supports, supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports.

Network providers are providers who work with the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.

➔ **Please note:** In-Home Supportive Services (IHSS) providers are not part of a network. You can select anyone to be your IHSS provider.

B. Rules for getting your health care, behavioral health, and long-term services and supports covered by the plan

Health Net Cal MediConnect covers all services covered by Medicare and Medi-Cal. This includes behavioral health, long-term services and supports (LTSS), and prescription drugs.

Health Net Cal MediConnect will generally pay for the health care services, behavioral health services, and LTSS you get if you follow the plan rules. To be covered:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 of this handbook.)
- The care must be **determined necessary.** By necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who has ordered the care or has told you to see another doctor**.** As a plan member, you must choose a network provider to be your PCP.

- » In most cases, your network PCP must give you approval before you can use other providers in the plan's network. This is called a **referral**. To learn more about referrals, see page 39.
- » You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 41.

➔ To learn more about choosing a PCP, see page 40.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 48.
  - » If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. If you are required to see a non-network provider, Prior Authorization will be required. Once authorization is approved, you, the requesting provider and the accepting provider will be notified of the approved Authorization. In this situation, we will cover the care at no cost to you. To learn about getting approval to see an out-of-network provider, see page 42
  - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - » When you first join the plan, you can make a request to us to continue to see your current providers. We are required to approve this request if you can show an existing relationship with the providers with some exceptions (see Chapter 1, page 7). If your request is approved, you can continue seeing the providers you see now for up to 6 months for services covered by Medicare and up to 12 months for services covered by Medi-Cal. During that time, our care coordinator will contact you to help you find providers in our network. After the first 6 months for Medicare services and 12 months for Medi-Cal services, we will no longer cover your care if you continue to see out-of-network providers. For help with transitioning your Medicare or Medi-Cal covered services as a new member of our plan, you can call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
  - » Members may get Family Planning services from any health care provider licensed to provide these services in or out of Health Net's network, and the services can be provided outside of your county of residence.

C. Your care coordinator

A care coordinator is one main person who works with you, with the health plan, and with your care providers to make sure you get the health care you need. A care coordinator will be assigned to you when you become a plan member.

The care coordinator will give you his/her phone number the first time you talk. A care coordinator helps put together healthcare services to meet your healthcare needs. He/She works with you to make your care plan. He/She helps you decide who will be on your care team. Your care coordinator gives you information you need to manage your healthcare. This will also help you make choices that are right for you. You can find out who your care coordinator is by calling Member Services.

If you would like to change your care coordinator, please contact Member Services.

If you need more help, please call our Member Services at 1-855-464-3571 (TTY: 711). Member Services is available 24 hours a day, seven days a week.

D. Getting care from primary care providers, specialists, other network medical providers, and out-of-network medical providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

When you become a member of our plan, you must choose a Health Net Cal MediConnect network provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. These include doctors providing general and/or family medical care, internists who provide internal medical care, and gynecologists who provide care for women. A nurse practitioner (NP), a State licensed registered nurse with special training, providing a basic level of health care, or a specialist can also act as your PCP.

You will get most of your routine or basic care from your PCP. Your PCP will also help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- your x-rays,

- laboratory tests,
- therapies,
- care from doctors who are specialists,
- hospital admissions, and
- follow-up care.

"Coordinating" your covered services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). For certain services, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan or your Medical Group. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

As we explained above, you will usually see your PCP first for most of your routine health care needs. When your PCP thinks that you need specialized treatment, he or she will need to give you a referral (approval in advance) to see a plan specialist or other certain providers. There are only a few types of covered services you may get without getting approval from your PCP first, as we explain below.

Each Member has a PCP. A PCP can even be a clinic. Women can choose an OB/GYN or family planning clinic as their PCP.

You may select a nonphysician medical practitioner as your Primary Care Provider. Nonphysician practitioners include: certified nurse midwives, certified nurse practitioners, and physicians assistants. You will be linked to the supervising Primary Care Provider, but you will continue to receive services from your chosen nonphysician practitioner. You are allowed to change your choice of practitioner by changing the supervising Primary Care Provider. Your ID card will be printed with the name of the supervising Primary Care Provider.

Picking a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as your PCP

An FQHC or RHC is a clinic and can be your PCP.

FQHCs and RHCs are health centers that provide primary care services. Call Member Services for the names and addresses of the FQHCs and RHCs that work with Health Net Cal MediConnect or look in the *Provider and Pharmacy Directory*.

How do you choose your PCP?

When you enroll in our plan, you will choose a contracting Medical Group from our network. You will also choose a PCP from this contracting Medical Group. The PCP you choose must be with a Medical Group within 30 miles or 30 minutes from where you live or work. Medical Groups (and their affiliated PCPs and hospitals) can be found in the *Provider and Pharmacy Directory* or you may visit our Web site at www.healthnet.com/calmediconnect. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week.

Each Medical Group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and hospitals are in the Medical Group and PCP's network. The name and office telephone number of your PCP is printed on your membership card.

If you do not choose a Medical Group or PCP or if you chose a Medical Group or PCP that is not available with this plan, we will automatically assign you to a Medical Group and PCP near your home.

For information on how to change your PCP, please see "Changing your PCP" below.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan network. If your PCP leaves our plan network, we can help you find a new PCP who is within our plan network.

Your request will be effective on the first day of the month following the date our plan receives your request. To change your PCP, call Member Services or visit our Web site at www.healthnet.com/calmediconnect to make your request.

When you contact us, be sure to let us know if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will let you know how you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before seeing other providers. This approval is called a **referral.** You can get services like the ones listed below without first getting approval from your PCP:

- Emergency services from network providers or out-of-network providers.
- Urgently needed care from network providers.
- Urgently needed care from out-of-network providers when you can't get to network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Member Services before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are eligible to receive services from Indian health providers, you may see these providers without a referral.

How to get care from specialists and other network providers

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

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

In order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

Each Medical Group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. This means that the Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your Medical Group or PCP uses these specialists or hospitals. You may generally change your PCP at any time if you want to see a plan specialist or go to a hospital that your current PCP can't refer you to. In this chapter under "Changing your PCP," we tell you how to change your PCP.

Some types of services will require getting approval in advance from our plan or your Medical Group (this is called getting "prior authorization"). Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP or other network provider will request the authorization from our plan or your Medical Group. The request will be reviewed and a decision (organization determination) will be sent to you and your provider. See the Benefits Chart in Chapter 4 of this booklet for the specific services that require prior authorization.

What if a network provider leaves our plan?

A network provider you are using might leave the plan.

Sometimes a specialist, clinic, hospital, or other network provider you are using might leave the plan.

If this happens, and it is a provider you see on a regular basis, we will make a good-faith effort to send you notification at least 30 days prior to the provider's termination effective date. If you continue seeing the provider after the termination effective date, you may have to pay for these services yourself. If you decide to switch to another network provider, Member Services can assist you in finding and selecting a provider.

Members that are currently undergoing treatment, seeing a specialist, receiving home health care, home infusion, or make use of durable medical equipment and who need assistance in transitioning their care to a new provider, contact Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week.

How to get care from out-of-network providers

➔ **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

If there is a certain type of service that you need and that service is not available in our plan's network, you will need to get prior authorization (approval in advance) first. Your PCP will request prior authorization from our plan or your Medical Group.

It is very important to get approval in advance before you see an out-of-network provider or receive services outside of our network (with the exception of emergency and urgently needed care, and kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area). If you don't get approval in advance, you may have to pay for these services yourself.

For information on coverage of out-of-network emergency and urgently needed care, please see Section H in this Chapter.

E. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) consist of Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and Nursing Facilities (NF). The services may occur in your home, community, or in a facility. The different types of LTSS are described below:

- **Community-Based Adult Services (CBAS)**: Outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services if you meet applicable eligibility criteria.
- **In-Home Supportive Services (IHSS):** A program that allows you to select your provider of in-home care if you cannot safely remain in your home without assistance. To qualify for IHSS, you must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program.
- **Multipurpose Senior Services Program (MSSP):** A California-specific program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

- **Nursing Facility (NF):** A facility that provides care for people who cannot safely live at home but who do not need to be in the hospital.

Your care coordinator will help you understand each program. To find out more about any of these programs, contact Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week.

F. How to get behavioral health (mental health & substance use disorder) services

You will have access to medically necessary behavioral health services that are covered by Medicare and Medi-Cal. Health Net Cal MediConnect provides access to behavioral health services covered by Medicare. Medi-Cal covered behavioral health services are not provided by Health Net Cal MediConnect, but will be available to eligible Health Net Cal MediConnect members through Los Angeles County Department of Mental Health (DMH) and Los Angeles County Department of Public Health (Substance Abuse Prevention & Control) (DPH/SAPC).

What Medi-Cal behavioral health services are provided outside of Health Net Cal MediConnect through Los Angeles County Department of Mental Health (DMH) and Los Angeles County Department of Public Health (Substance Abuse Prevention & Control) (DPH/SAPC)?

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet Medi-Cal specialty mental health services medical necessity criteria. Medi-Cal specialty mental health services provided by Los Angeles County Department of Mental Health (DMH) and Los Angeles County Department of Public Health (Substance Abuse Prevention & Control) (DPH/SAPC) include:

- Mental health services (assessment, therapy, rehabilitation, collateral, and plan development)
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention
- Crisis stabilization
- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Psychiatric inpatient hospital services

- Targeted case management

Drug Medi-Cal services are available to you through Los Angeles County Department of Public Health (Substance Abuse Prevention & Control) (DPH/SAPC) if you meet the Drug Medi-Cal medical necessity criteria. Drug Medi-Cal services provided by Los Angeles County Department of Public Health (Substance Abuse Prevention & Control) (DPH/SAPC) include:

- Intensive outpatient treatment services
- Residential treatment services
- Outpatient drug free services
- Narcotic treatment services
- Naltrexone services for opioid dependence

In addition to the Drug Medi-Cal services listed above, you may have access to voluntary inpatient detoxification services if you meet the medical necessity criteria.

You will also have access to medically necessary behavioral health services that are covered by Medicare and administered through the Health Net Cal MediConnect Mental Health Network. Behavioral health services include, but are not limited to:

- Outpatient services: Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to substance use disorder.
- Inpatient services and supplies: Accommodations in a room of two or more beds, including special treatment units, supplies and ancillary services normally provided by the facility.
- Inpatient and alternate levels of care: partial hospitalization and intensive outpatient services
- Detoxification: Inpatient services for acute detoxification and treatment of acute medical conditions relating to substance use disorder
- Emergency services: screening, examination and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition

For provider information, please look in your *Provider and Pharmacy Directory*. You may also contact Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week, or visit our website at www.healthnet.com/calmediconnect.

Behavioral Health services exclusions and limitations

For a list of behavioral health services exclusions and limitations, please see Chapter 4, Section E: Benefits *not* covered by the plan.

Process used to determine medical necessity for behavioral health services

The plan must authorize certain behavioral health services and supplies to be covered. For details on services that may require prior authorization, please refer to Chapter 4. To get authorization for these services, you must call Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week. The plan will refer you to a nearby contracted mental health professional who will evaluate you to determine if more treatment is needed. If you need treatment, the contracted mental health professional will create a treatment plan and send that plan to Health Net for review. The services included in the treatment plan will be covered when authorized by the plan. If the plan does not approve the treatment plan, no more services or supplies will be covered for that condition. However, the plan may direct you to the county mental health department to assist you in getting the care you need.

Referral procedures between Health Net Cal MediConnect and Los Angeles County

Referrals for Health Net Cal MediConnect Behavioral Health services can be made from many sources, including: county behavioral health providers, county case managers, PCPs, members and their families. These referring sources can contact Health Net by calling the number that appears on your identification (ID) card. Health Net will confirm eligibility and authorize the services when appropriate.

Heath Net will work with Los Angeles County to provide appropriate referral and care coordination for you.

Referrals for County Specialty Mental Health and/or Alcohol & Drug Services may be made directly by you.

Care coordination services include the coordination of services between PCPs, County Behavioral Health providers, county case managers, you, and your family or caregiver, as appropriate.

What to do if you have a problem or complaint about a behavioral health service

The benefits included in this section are subject to the same appeals process as any other benefit. See Chapter 9, What to do if you have a problem or complaint (coverage decisions, appeals, complaints), for information about making complaints.

Continuity of care for members who are currently receiving behavioral health services

If you are currently receiving behavioral health services, you can request to keep seeing your provider. We are required to approve this request if you can show an existing relationship with your provider. If your request is approved, you can continue seeing the provider you see

now for up to 12 months. After the first 12 months, we may no longer cover your care if you continue to see the out-of-network provider. For assistance with your request, please call Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

G. How to get transportation services

Health Net Cal MediConnect is partnering with LogistiCare Solutions to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services to Health Net members enrolled in the Cal MediConnect Program.

Non-Emergency Medical Transportation

For information on Non-Emergency Medical Transportation, please refer to the Benefits Chart in Chapter 4 of this member handbook.

Non-Medical Transportation

NMT includes transportation to medical services by passenger car, taxi, or other forms of public /private conveyances provided by persons not registered as Medi-Cal providers.

NMT transportation does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated members by ambulance, littler van or wheelchair van medical transportation services.

The NMT transportation benefit consists of:

- 30 one-way trips per member per calendar year with no charge
- Curb-to-curb or door-to-door service (depending on your needs)
- Taxi, standard passenger vehicle, mini-van,
- Service to and from medical appointments or from residence
- No limitation on mileage within the service area
- Inclusion of one family member or caretaker on the transport at no additional cost
- You may ask the driver to stop at a pharmacy, radiology provider or laboratory facility from a physician's office (not counted as a separate trip)

To request transportation services described above, contact Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

The transportation request must be submitted seven business days in advance.

H. How to get covered services when you have a medical emergency or urgent need for care

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

- Placing the person's health in serious risk; ***or***
- Serious harm to bodily functions; ***or***
- Serious dysfunction of any bodily organ or part; ***or***
- In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - » There is not enough time to safely transfer the member to another hospital before delivery.
  - » The transfer may pose a threat to the health or safety of the member or unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact Member Services at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4.

Coverage is limited to the United States and its territories: the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

There are some exceptions under Medicare as follows:

There are three situations when Medicare may pay for certain types of health care services you get in a foreign hospital (a hospital outside the U.S.): 1. You're in the U.S. when you have a medical emergency, and the foreign hospital is closer than the nearest U.S. hospital that can treat your illness or injury. 2. You're traveling through Canada without unreasonable delay by the most direct route between Alaska and another state when a medical emergency occurs, and the Canadian hospital is closer than the nearest U.S. hospital that can treat your illness or injury. Medicare determines what qualifies as "without unreasonable delay" on a case-by-case basis. 3. You live in the U.S. and the foreign hospital is closer to your home than the nearest U.S. hospital that can treat your medical condition, regardless of whether it's an emergency. In these situations, Medicare will pay only for the Medicare-covered services you get in a foreign hospital.

Medi-Cal coverage is limited to the United States and its territories, except for Emergency Services requiring hospitalization in Canada or Mexico.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by us. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- You go to a network provider, ***or***
- The additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- You get this care from a network provider, ***and***
- You follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

In serious emergency situations: Call "911" or go to the nearest hospital.

If your situation is not so severe: Call your PCP or Medical Group or, if you cannot call them or you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your Medical Group or PCP for help.

Your Medical Group is available 24 hours a day, seven days a week, to respond to your phone calls regarding medical care that you believe is needed immediately. They will evaluate your situation and give you directions about where to go for the care you need.

If you are not sure whether you have an emergency or require urgent care, please contact a clinician by calling Nurse24 toll free at 1-800-893-5597 (TTY: 1-800-276-3821) 24 hours a day, 7 days a week.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States and its territories.

I. What if you are billed directly for the full cost of services covered by our plan?

If a provider sends you a bill instead of sending it to the plan, you should ask us to pay our share of the bill.

➔ You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If you have paid for your covered services, or if you have paid more than your share for covered services, or if you have gotten a bill for the full cost of covered medical services, see Chapter 7 to learn what to do.

What should you do if services are not covered by our plan?

Health Net Cal MediConnect covers all services:

- That are determined necessary, ***and***
- That are listed in the plan's Benefits Chart (see Chapter 4)*,* ***and***
- That you get by following plan rules.

➔ If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 explains what to do if you want us to cover a medical item or service. It also tells you how to appeal our coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

J. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare approves the study. If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You do need to tell us before you start participating in a clinical research study.
Here's why:

- We can tell you if the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

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

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (http://www.medicare.gov/publications/pubs/pdf/02226.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services).

Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

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

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - » You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - » You must get approval from us before you are admitted to the facility or your stay will not be covered.

Medi-Cal (Medicaid) may provide some coverage for care in religious non-medical health care institutions. For more information, please contact your local social services office (phone numbers are in Chapter 2, Section J of this booklet) or Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

L. Rules for owning durable medical equipment

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

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months.

As a member of our plan, you may acquire ownership of rented durable medical equipment as long as it is medically necessary and you have a long-term need for the item. In addition, the item must be authorized, arranged for and coordinated by your PCP, Medical Group and/or Health Net. Call Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week to find out about the rental or ownership requirements of durable medical equipment and the documentation you need to provide.

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

You will have to make 13 new payments in a row under Original Medicare to own the equipment if:

- You did not become the owner of the durable medical equipment item while you were in our plan ***and***
- You leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

The payments you made while you were in our plan do not count toward these 13 payments.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare.

Chapter 4: Benefits Chart

Table of Contents

A. Understanding your covered services

This chapter tells you what services our plan pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5. This chapter also explains limits on some services.

Because you get assistance from Medi-Cal, you pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3 for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator *and/or* Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.

B. Our plan does not allow providers to charge you for services

We do not allow our providers to bill you for services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

➔ **You should never get a bill from a provider. If you do, see Chapter 7.**

C. About the Benefits Chart

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described below.

- Your Medicare and Medi-Cal covered services must be provided according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. Medically Necessary/Medical Necessity refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we will not pay for care you get from an out-of-network provider. Chapter 3 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can see other network providers. This is called a referral. Chapter 3 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization*. Covered services that need approval first are marked in the Benefits Chart *in italic type.*

All preventive services are free. You will see this apple 🍎 next to preventive services in the benefits chart.

D. The Benefits Chart

Services that our plan pays for
Abdominal aortic aneurysm screening We will pay only once for an ultrasound screening for people at risk. You must get a referral for it at your "Welcome to Medicare" preventive visit. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Alcohol misuse screening and counseling We will pay for one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting. *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by us. In cases that are *not* emergencies, we *may* pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for
Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We will pay for this once every 12 months.
Bone mass measurement We will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We will pay for the services once every 24 months, or more often if they are medically necessary. We will also pay for a doctor to look at and comment on the results. *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Breast cancer screening (mammograms) We will pay for the following services: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Clinical breast exams once every 24 months
Cardiac (heart) rehabilitation services We will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's referral. We also cover *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for

Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)

We pay for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may:

- Discuss aspirin use,
- Check your blood pressure, and/or
- Give you tips to make sure you are eating well.

Cardiovascular (heart) disease testing

We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.

You should talk to your provider and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Cervical and vaginal cancer screening

We will pay for the following services:

- For all women: Pap tests and pelvic exams once every 24 months
- For women who are at high risk of cervical cancer: one Pap test every 12 months
- For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months

Chiropractic services

We will pay for the following services:

- Adjustments of the spine to correct alignment

You should talk to your provider and get a referral.

Services that our plan pays for
Prior authorization (approval in advance) may be required to be covered, except in an emergency.
Colorectal cancer screening For people 50 and older, we will pay for the following services: ▪ Flexible sigmoidoscopy (or screening barium enema) every 48 months ▪ Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we will pay for one screening colonoscopy (or screening barium enema) every 24 months For people not at high risk of colorectal cancer, we will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy). *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Community-Based Adult Services (CBAS) CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We will pay for CBAS if you meet the eligibility criteria. ***Note: If a CBAS facility is not available, we can provide these services unbundled.*** *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: ▪ We will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits.

Services that our plan pays for
If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: ▪ We will pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.* If you are pregnant, you may receive unlimited tobacco cessation counseling with prior authorization. Our plan also covers additional online and telephonic smoking cessation counseling without prior authorization. Please contact Member Services for more information.
Dental services Certain dental services, including dentures, will be provided by the state's Denti-Cal program starting May 1, 2014. These services are not provided through our plan. For more information, call Denti-Cal at 1-800-322-6384. TTY users should call 1-800-735-2922. We will pay for the following services: Specific routine dental care services not provided by Medi-Cal Dental, including preventive and diagnostic services, restorative services, endodontic services, periodontic services and partial dentures. **Coverage Limitations:** • Oral examinations are covered once every six (6) consecutive months. • Periodontal maintenance is covered once every six (6) consecutive months. • Crowns and pontics are benefits on the same tooth only once every five (5) years, and consistent with professionally recognized standards of dental practice. • Replacement of partial dentures are covered once per arch every five (5) years, except when they cannot be made functional through reline or repair. • Denture relines are covered two (2) times per year, and only when consistent with professionally recognized standards of dental practice. For a list of dental exclusions under this plan, please refer to Section E later in this Chapter.

Services that our plan pays for
If the covered benefit is upgraded to include noble or high noble metal, the provider may charge you the additional lab cost of the upgraded metal. Porcelain/resin fused to metal crowns on molar teeth is considered an upgrade. If a porcelain/resin fused to metal crown on a molar tooth is provided, the provider may charge you the additional lab cost of the porcelain/resin. If the covered anterior fixed bridge is upgraded to include noble or high noble metal, the provider may charge you the additional lab cost of the upgraded metal. For additional detailed coverage information, up-to-date Primary Care Dentist information, or to obtain authorization to receive services, please contact Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. Interpreter Services are available by calling Member Services. Or, visit the Health Net web site at www.healthnet.com for a list of Health Net's participating providers in your area.
Depression screening We will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. *You should talk to your provider and get a referral.*

Services that our plan pays for

Diabetes screening

We will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:

- High blood pressure (hypertension)
- History of abnormal cholesterol and triglyceride levels (dyslipidemia)
- Obesity
- History of high blood sugar (glucose)

Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.

Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.

You should talk to your provider and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Services that our plan pays for

Diabetic self-management training, services, and supplies

We will pay for the following services for all people who have diabetes (whether they use insulin or not):

- Supplies to monitor your blood glucose, including the following:
  - » A blood glucose monitor
  - » Blood glucose test strips
  - » Lancet devices and lancets
  - » Glucose-control solutions for checking the accuracy of test strips and monitors
- For people with diabetes who have severe diabetic foot disease, we will pay for the following:
  - » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or***
  - » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)

  We will also pay for fitting the therapeutic custom-molded shoes or depth shoes.
- We will pay for training to help you manage your diabetes, in some cases.

You should talk to your provider and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Services that our plan pays for

Durable medical equipment and related supplies

(For a definition of "Durable medical equipment," see Chapter 12 of this handbook.)

The following items are covered:

- Wheelchairs
- Crutches
- Hospital beds
- Nebulizers
- Oxygen equipment
- IV infusion pumps
- Walkers

Other items *may* be covered.

We will pay for all medically necessary durable medical equipment that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Emergency care

Emergency care means services that are:

- Given by a provider trained to give emergency services, ***and***
- Needed to treat a medical emergency.

A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

- Placing the person's health in serious risk; ***or***
- Serious harm to bodily functions; ***or***
- Serious dysfunction of any bodily organ or part; ***or***
- In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - » There is not enough time to safely transfer the member to another hospital before delivery.
  - » The transfer may pose a threat to the health or safety of the member or unborn child.

Services that our plan pays for
If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay. Coverage is limited to the United States and its territories: the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. There are some exceptions under Medicare. Please see Chapter 3, Section H for additional information.

Services that our plan pays for

Family planning services

The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.

We will pay for the following services:

- Family planning exam and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants)
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)
- Counseling and diagnosis of infertility, and related services
- Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions
- Treatment for sexually transmitted infections (STIs)
- Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)
- Genetic counseling

We will also pay for some other family planning services. However, you must see a provider in our provider network for the following services:

- Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)
- Treatment for AIDS and other HIV-related conditions
- Genetic testing

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Health and wellness education programs

We offer many programs that focus on certain health conditions. These include:

- Health Education classes;
- Nutrition Education classes;
- Smoking and Tobacco Use Cessation; and

Services that our plan pays for
▪ Nursing Hotline *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We will also pay for hearing aids, including: ▪ Molds, supplies, and inserts ▪ Repairs that cost more than $25 per repair ▪ An initial set of batteries ▪ Six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid ▪ Trial period rental of hearing aids The cost of hearing aid benefit services, including sales tax, is limited to $1,510 per fiscal year. If you are pregnant or reside in a nursing facility, the $1,510 maximum benefit amount does not apply to you. Replacement of hearing aids that are lost, stolen or destroyed due to circumstance beyond your control is not included in the $1,510 maximum benefit amount. *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
HIV screening We pay for one HIV screening exam every 12 months for people who: ▪ Ask for an HIV screening test, ***or*** ▪ Are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.

Services that our plan pays for
You should talk to your provider and get a referral. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. We will pay for the following services, and maybe other services not listed here: ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies Prior authorization (approval in advance) may be required to be covered, except in an emergency.
Hospice care You can get care from any hospice program certified by Medicare. When you are in a hospice program certified by Medicare, your hospice services and your Medicare Part A and B services related to your terminal illness are paid for by Medicare. Health Net Cal MediConnect does not pay for your services. Your hospice doctor can be a network provider or an out-of-network provider. Hospice care covers the following services: ▪ Drugs to treat symptoms and pain ▪ Short-term respite care ▪ Home care ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:*** ▪ The hospice provider will bill Medicare for your services. Medicare will pay for hospice services and any Medicare Part A or B services. You pay nothing for these services.

Services that our plan pays for

For services covered by Medicare Part A or B that are not related to your terminal illness (except for emergency care or urgently needed care):

- The provider will bill us for your services. The plan will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For services covered by our plan but not covered by Medicare Part A or B:

- We will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal illness. You pay nothing for these services.

Note: **If you need non-hospice care, you should call your care coordinator to arrange the services. Non-hospice care is care that is not related to your terminal illness.**

Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Immunizations

We will pay for the following services:

- Pneumonia vaccine
- Flu shots, once a year, in the fall or winter
- Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B
- Other vaccines if you are at risk and they meet Medicare Part B coverage rules

We will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more.

Prior authorization (approval in advance) is not required for the Pneumonia vaccine or flu shots.

You should talk to your provider and get a referral for Hepatitis B or other vaccines.

Prior authorization (approval in advance) may be required to be covered, except in an emergency, for Hepatitis B or other vaccines.

Services that our plan pays for

In-Home Supportive Services (IHSS)

We will pay for services provided to you so that you can remain safely in your own home.

The types of IHSS which can be authorized through the County Department of Social Services are:

- Housecleaning
- Meal preparation
- Laundry
- Grocery shopping
- Personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services)
- Accompaniment to medical appointments
- Protective supervision for the mentally impaired

To qualify for IHSS, you must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program.

If eligible, you may receive up to 283 hours of IHSS if approved by your county social worker.

Inpatient hospital care

We will pay for the following services, and maybe other services not listed here:

- Semi-private room (or a private room if it is medically necessary)
- Meals, including special diets
- Regular nursing services
- Costs of special care units, such as intensive care or coronary care units
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Needed surgical and medical supplies
- Appliances, such as wheelchairs
- Operating and recovery room services

Services that our plan pays for
▪ Physical, occupational, and speech therapy ▪ Inpatient substance abuse services ▪ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant.Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If our plan provides transplant services at a distant location (farther away than the normal community patterns of care) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. ▪ Blood, including storage and administration ▪ Physician services You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Inpatient mental health care We will pay for mental health care services that require a hospital stay. ▪ If you need inpatient services in a freestanding psychiatric hospital, we will pay for the first 190 days. After that, the local county mental health agency will pay for inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days will be coordinated with the local county mental health agency. o The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. ▪ If you are 65 years or older, we will pay for services received in an Institute for Mental Diseases (IMD). *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for

Inpatient services covered during a non-covered inpatient stay

If your inpatient stay is not reasonable and needed, we will not pay for it.

However, in some cases we will pay for services you get while you are in the hospital or a nursing facility. We will pay for the following services, and maybe other services not listed here:

- Doctor services
- Diagnostic tests, like lab tests
- X-ray, radium, and isotope therapy, including technician materials and services
- Surgical dressings
- Splints, casts, and other devices used for fractures and dislocations
- Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:
  - » Replace all or part of an internal body organ (including contiguous tissue), or
  - » Replace all or part of the function of an inoperative or malfunctioning internal body organ.
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition
- Physical therapy, speech therapy, and occupational therapy

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Kidney disease services and supplies

We will pay for the following services:

- Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. We will cover up to six sessions of kidney disease education services.
- Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3.

Services that our plan pays for

- Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care
- Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments
- Home dialysis equipment and supplies
- Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply.

You should talk to your provider and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.

Services that our plan pays for

Medical nutrition therapy

This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor.

We will pay for three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year.

You should talk to your provider and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Medicare Part B prescription drugs

These drugs are covered under Part B of Medicare. We will pay for the following drugs:

- Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)

Services that our plan pays for
▪ IV immune globulin for the home treatment of primary immune deficiency diseases *Prior authorization (approval in advance) may be required to be covered, except in an emergency.* ➔ **Chapter 5 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.**
Multipurpose Senior Services Program (MSSP) MSSP is a case management program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals. To be eligible, you must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP services include: ▪ Adult Day Care / Support Center ▪ Housing Assistance ▪ Chore and Personal Care Assistance ▪ Protective Supervision ▪ Care Management ▪ Respite ▪ Transportation ▪ Meal Services ▪ Social Services ▪ Communications Services This benefit is covered up to $4,285 per year. *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for

Non-emergency medical transportation

This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with paratransit.

The forms of transportation are authorized when:

- Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and
- Transportation is required for the purpose of obtaining needed medical care.

Depending on the service, prior authorization may be required.

Non-medical transportation

This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.

You will have access to 30 one-way trips per year.

This benefit does not limit your non-emergency medical transportation benefit.

Please refer to Chapter 3, Section G for additional information on Transportation services.

Nursing facility care

A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.

Services that we will pay for include, but are not limited to, the following:

- Semiprivate room (or a private room if it is medically needed)
- Meals, including special diets
- Nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)
- Blood, including storage and administration

Services that our plan pays for

- Medical and surgical supplies usually given by nursing facilities
- Lab tests usually given by nursing facilities
- X-rays and other radiology services usually given by nursing facilities
- Use of appliances, such as wheelchairs usually given by nursing facilities
- Physician/practitioner services
- Durable medical equipment
- Dental services, including dentures
- Acupuncture
- Vision benefits
- Hearing exams
- Hearing Aids
- Chiropractic care
- Podiatry services

You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).
- A nursing facility where your spouse is living at the time you leave the hospital.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Obesity screening and therapy to keep weight down

If you have a body mass index of 30 or more, we will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.

You should talk to your provider and get a referral.

Services that our plan pays for

Outpatient diagnostic tests and therapeutic services and supplies

We will pay for the following services, and maybe other services not listed here:

- X-rays
- Radiation (radium and isotope) therapy, including technician materials and supplies
- Surgical supplies, such as dressings
- Splints, casts, and other devices used for fractures and dislocations
- Lab tests
- Blood, including storage and administration
- Other outpatient diagnostic tests
- Diagnostic radiological services (includes complex tests such as CT, MRI, MRA, SPECT)

You should talk to a doctor and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Services that our plan pays for

Outpatient hospital services

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

We will pay for the following services, and maybe other services not listed here:

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

You should talk to a doctor and get a referral.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Services that our plan pays for
Outpatient mental health care We will pay for mental health services provided by: ▪ A state-licensed psychiatrist or doctor ▪ A clinical psychologist ▪ A clinical social worker ▪ A clinical nurse specialist ▪ A nurse practitioner ▪ A physician assistant ▪ Any other Medicare-qualified mental health care professional as allowed under applicable state laws We will pay for the following services, and maybe other services not listed here: ▪ Clinic services ▪ Day treatment ▪ Psychosocial rehab services ▪ Partial hospitalization/Intensive outpatient programs ▪ Individual and group mental health evaluation and treatment ▪ Psychological testing when clinically indicated to evaluate a mental health outcome ▪ Outpatient services for the purposes of monitoring drug therapy ▪ Outpatient laboratory, drugs, supplies and supplements ▪ Psychiatric consultation *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Outpatient rehabilitation services We will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. *You should talk to a doctor and get a referral for physical and speech therapy services.* *Prior authorization (approval in advance) may be required to be covered, except in an*

Services that our plan pays for
emergency.
Outpatient substance abuse services We will pay for the following services, and maybe other services not listed here: ▪ Alcohol misuse screening and counseling ▪ Treatment of drug abuse ▪ Group or individual counseling by a qualified clinician ▪ Subacute detoxification in a residential addiction program ▪ Alcohol and/or drug services in an intensive outpatient treatment center ▪ Extended release Naltrexone (vivitrol) treatment *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Outpatient surgery We will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. *You should talk to a doctor and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Partial hospitalization services *Partial hospitalization* is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. *Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for

Physician/provider services, including doctor's office visits

We will pay for the following services:

- Medically necessary health care or surgery services given in places such as:
  - » Physician's office
  - » Certified ambulatory surgical center
  - » Hospital outpatient department
- Consultation, diagnosis, and treatment by a specialist
- Basic hearing and balance exams given by your primary care provider *or* specialist, if your doctor orders it to see whether you need treatment
- Second opinion by another network provider before a medical procedure
- Non-routine dental care. Covered services are limited to:
  - » Surgery of the jaw or related structures
  - » Setting fractures of the jaw or facial bones
  - » Pulling teeth before radiation treatments of neoplastic cancer
  - » Services that would be covered when provided by a physician

You should talk to your provider and get a referral to see a specialist.

Podiatry services

We will pay for the following services:

- Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)
- Routine foot care for members with conditions affecting the legs, such as diabetes

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Prostate cancer screening exams

For men age 50 and older, we will pay for the following services once every 12 months:

Services that our plan pays for
▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for

Prosthetic devices and related supplies

Prosthetic devices replace all or part of a body part or function. We will pay for the following prosthetic devices, and maybe other devices not listed here:

- Colostomy bags and supplies related to colostomy care
- Pacemakers
- Braces
- Prosthetic shoes
- Artificial arms and legs
- Breast prostheses (including a surgical brassiere after a mastectomy)
- Incontinence cream and diapers

We will also pay for some supplies related to prosthetic devices. We will also pay to repair or replace prosthetic devices.

We offer some coverage after cataract removal or cataract surgery. See “Vision Care” later in this section for details.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Pulmonary rehabilitation services

We will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.

We will pay for respiratory services for ventilator-dependent patients.

Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Sexually transmitted infections (STIs) screening and counseling

We will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.

Services that our plan pays for
We will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office. *You should talk to your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
Skilled nursing facility care We will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets ▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Blood, including storage and administration ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: ▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse lives at the time you leave the hospital

Services that our plan pays for
Prior authorization (approval in advance) may be required to be covered, except in an emergency.

Services that our plan pays for

Urgent care

Urgent care is care given to treat:

- A non-emergency, ***or***
- A sudden medical illness, ***or***
- An injury, ***or***
- A condition that needs care right away.

If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.

Our plan does not cover urgently needed care or any other care that you get outside the United States and its territories. Please see Chapter 3 for additional information on Urgent Care.

Vision care

We will pay for the following services:

- One routine eye exam every year*and
- Basic single vision, bifocal or trifocal eyeglass lenses every 2 years*, ** and
- Up to $100 for eyeglass frames every two years*, **, or
- Up to $100 for elective contact lenses, fitting and evaluation every two years*, **, ***.
- Low vision exam****
- Low vision aid materials****

*From the date of service/purchase, multi-year benefits may not be available in subsequent years.

**You receive a 20% discount off any balance over the $100 frame allowance and are responsible for 100% of any remaining balance over the $100 contact lenses allowance.

***Visually necessary contact lenses, fitting and evaluation are paid in full every two years.

****Coverage limited to pregnant women or people who reside in a skilled nursing facility when diagnosis and prescription criteria are met. Covered services include:

Exam: professional evaluation, fitting of the low vision aid and subsequent supervision, if appropriate, including six months follow-up care.

Services that our plan pays for

- Low vision aid materials:
- Hand held low vision aids and other non-spectacle mounted aids
- Single lens spectacle mounted low vision aids

Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound lens system

Medical Eye Services:

Prior authorization (approval in advance) may be required for Medicare-covered vision exams and Medicare-covered eyewear, except in an emergency.

Medical Eye Services are provided by or arranged by your PCP. We will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.

For people at high risk of glaucoma, we will pay for one glaucoma screening each year. People at high risk of glaucoma include:

- People with a family history of glaucoma
- People with diabetes
- African-Americans who are age 50 and older
- Hispanic Americans who are 65 or older

We will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) We will also pay for corrective lenses, frames, and replacements if you need them after a cataract removal without a lens implant.

How to use your vision benefits

This plan provides coverage for a routine eye exam annually and eyewear every 24 months. These vision benefits are administered by Vision Service Plan (VSP). You will obtain your annual routine vision examination (to determine the need for corrective eyewear) and any applicable eyewear through VSP, not your medical group.

VSP will pay the provider for covered services specified in this benefit summary. You will be responsible for payment of non-covered services, such as any amount over your frame allowance or cosmetic lens options like scratch coatings, progressive lenses, tints, etc. The payment you make for these non-covered services will be made directly

Services that our plan pays for

to your VSP provider.

Make arrangements for your annual routine vision examination with a VSP participating provider. At your appointment tell them you have VSP through Health Net Cal MediConnect. Vision care provided by someone other than a VSP participating provider will not be covered. To locate a VSP participating provider, call Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. Or you can look one up online at www.vsp.com/advantage.

You are able to purchase eyewear from the provider who performed your examination or from a list of VSP participating eyewear providers in your service area. Eyewear supplied by providers other than VSP participating providers are not covered. To locate a VSP participating provider, call Health Net Cal MediConnect Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. Or you can look one up online at www.vsp.com/advantage.

VSP will make direct payment(s) to the participating provider for the covered vision exam and/or eyewear provided to you.

You will be responsible for payment of any services or eyewear material that is not covered by your VSP routine benefit. Applicable payments should be made directly to your VSP provider.

That's all you need to do to get your routine vision exam and new eyeglasses or contact lenses. The VSP participating provider will take care of all of the paperwork and billing for you.

For a list of Non-Medicare Covered Routine Vision and Eyewear exclusions, please see Section E later in this Chapter.

"Welcome to Medicare" Preventive Visit

We cover the one-time "Welcome to Medicare" preventive visit. The visit includes:

- A review of your health,
- Education and counseling about the preventive services you need (including screenings and shots), and
- Referrals for other care if you need it.

Important: We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.

E. Benefits *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that we do not pay for these benefits.

The list below describes some services and items that are not covered by us under any conditions and some that are excluded by us only in some cases.

We will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Medi-Cal will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, the following items and services are not covered by our plan:

- Services considered not “reasonable and medically necessary,” according to the standards of Medicare and Medi-Cal, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See pages 50 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- A private room in a hospital, except when it is medically needed.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Regular hearing exams, hearing aids, or exams to fit hearing aids (except for coverage as stated under "Hearing Services" in the Benefits Chart earlier in this Chapter).
- Reversal of sterilization procedures, sex change operations (with the exception of medically necessary transgender services covered under Medi-Cal), and non-prescription contraceptive supplies.
- Acupuncture services except treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition for nursing facility residents and pregnant beneficiaries.
- Naturopath services (the use of natural or alternative treatments).

- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.
- Court-ordered testing and treatment, except when medically necessary and within the allowable visits under the plan contract.
- Treatment at a Residential Treatment Center. This benefit may be available under the county specialty mental health benefit.
- Ancillary services such as: vocational rehabilitation and other rehabilitation services (this benefit may be available under the county specialty mental health benefit) and nutrition services.
- Psychological testing, except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer-based reports.
- Damage to a hospital or facility caused by you.
- Treatment for biofeedback or hypnotherapy.
- Services received out of your primary state of residence, except in the event of Emergency Services and as otherwise authorized by Health Net.
- Electro-Convulsive Therapy (ECT), except as authorized by Health Net

Non Medi-Cal Covered Dental exclusions

- Replacement of lost or stolen dental prosthetics or appliances, including crowns, bridges, partial dentures and full dentures.
- Any dental treatment requested, or appliances made, which are either not necessary for maintaining or improving dental health, or are for cosmetic purposes, unless otherwise covered as a benefit.
- Orthodontic treatment.
- General anesthesia, analgesia, intravenous/intramuscular sedation or the services of an anesthesiologist for dental covered services under this plan.
- Dental appliances needed to increase vertical dimension or restore occlusion.
- Any dental services performed outside of the assigned dental office, unless expressly authorized

by the plan, or unless as outlined and covered as "Emergency Care" in this Member Handbook.

Non-Medicare Covered Routine Vision and Eyewear exclusions:

- Radial keratotomy, LASIK surgery, and vision therapy. *Contact the plan for information on discounts for LASIK procedures.*
- Orthoptics or vision training and any associated supplemental testing.
- Corneal Refractive Therapy (CRT).
- Orthokeratology (a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Refitting of contact lenses after the initial (90-day) fitting period.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter).
- Two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes (for covered surgical treatments, please refer to the Benefits Chart earlier in this chapter).
- Corrective vision treatment of an Experimental Nature.
- Plano contact lenses to change eye color cosmetically.
- Costs for services and/or materials exceeding Plan Benefit allowances.
- Artistically-painted contact lenses.
- Contact lens modification, polishing or cleaning.
- Additional office visits associated with contact lens pathology.
- Contact lens insurance policies or service agreements.
- Vision services or supplies provided by a provider other than a VSP participating provider.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Vision Care benefits. Please refer to the Benefits Chart earlier in this chapter or Chapters 5 and 6 for more information about outpatient prescription drugs under your medical or prescription drug benefits.
- Vision aids (other than Eyeglasses or Contact Lenses).
- Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under the plan.
- Vision services or materials provided by any other group benefit plan providing vision care.

- Visions services rendered after your coverage ends, except when materials that were ordered before coverage ended are delivered and the services rendered to you are within 31 days from the date of such order.
- Vision services provided as a result of any Workers' Compensation laws, or similar legislation, or required by any governmental agency or program, whether federal, state, or subdivisions thereof.
- Vision services and/or materials not indicated in this Member Handbook.

Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medi-Cal. Chapter 6 tells you what you pay for these drugs.

Health Net Cal MediConnect also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4.

Rules for the plan's outpatient drug coverage

We will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. You must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page 108 to learn about asking for an exception.
4. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books. Medically Necessary refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, we will pay for prescriptions *only* if they are filled at any of our network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill us for our share of the cost of your covered prescription drug. You will need to pay the pharmacy a co-pay when you pick up your prescription.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up.* You can then ask us to pay you back for our share. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

➔ To learn how to ask us to pay you back, see Chapter 7.

➔ If you need help getting a prescription filled, you can contact Member Services.

What if you want to change to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

➔ If you need help changing your network pharmacy, you can contact Member Services.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home. Usually, long-term care facilities have their own pharmacies. Residents may get prescription drugs through a facility's pharmacy as long as it is part of our network. If your long-term care facility's pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.

Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. A 90-day supply has the same co-pay as a one-month supply.

To get order forms and information about filling your prescriptions by mail, visit our website (www.healthnet.com/calmediconnect), or call Member Services (phone numbers are on the bottom of this page) for assistance.

Usually, a mail-order prescription will get to you within 14 days. If your mail order is delayed, call Member Services (phone numbers are on the bottom of this page) for assistance.

Can you get a long-term supply of drugs?

You can get a long-term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long-term medical condition. When you get a long-term supply of drugs, your co-pay may be lower.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same co-pay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- If you do not receive more than a 30-day supply, and
- If there is no network pharmacy that is close to you and open, or
- If you need a drug that you can't get at a network pharmacy close to you, or
- If you need a drug for emergency or urgent medical care, or
- If you must leave your home due to a federal disaster or other public health emergency.

We will also pay if you are getting a vaccine in your doctor's office that is not covered by Medicare Part B.

➔ In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost instead of a co-pay when you get your prescription. You can ask us to pay you back for our share of the cost.

➔ To learn more about this, see Chapter 7.

B. The plan's Drug List

We have a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by us with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs and products covered under your Medi-Cal benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.healthnet.com/calmediconnect. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

We do not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow us to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Health Net Cal MediConnect will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medi-Cal.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are cost-sharing tiers?

Every drug on our Drug List is in one of 3 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Tier 1 drugs have a low copay. They are generic drugs. The copay will be from $0.00 to $2.55. This depends on your level of Medi-Cal coverage.
- Tier 2 drugs have a higher copay. They are brand name drugs. The copay will be from $0.00 to $6.35. This depends on your level of Medi-Cal coverage.
- Tier 3 drugs have a copay of $0.00. They are prescription and OTC drugs that Medi-Cal covers.

To find out which cost-sharing tier your drug is in, look for the drug on our Drug List.

➔ Chapter 6 tells the amount you pay for drugs in each tier.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, we expect your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. Your co-pay may be greater for the brand-name drug than for the generic drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Health Net Cal MediConnect before you fill your prescription. If you don't get approval, Health Net Cal MediConnect may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs (that often are as effective) before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first. If Drug A does not work for you, we will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, we might limit:

- How many refills you can get, ***or***
- How much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at www.healthnet.com/calmediconnect.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by our plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above, some of the drugs covered by our plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

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

You can get a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. **The drug you have been taking:**
   - Is no longer on our Drug List, ***or***
   - Was never on our Drug List, ***or***
   - Is now limited in some way.
2. **You must be in one of these situations:**
   - **You are new to our plan and do not live in a long-term care facility.**

     We will cover a supply of your drug **one time only during the first** *90 days* **of your membership** in the plan. This supply will be for up to *a 30-day supply*, or less if your prescription is written for fewer days. You must fill the prescription at a network pharmacy.
   - **You are new to the plan and live in a long-term care facility.**

     We will cover a supply of your drug **during the first** *90 days* **of your membership** in the plan, until we have given you a 102-day supply consistent with the dispensing increment, or less if your prescription is written for fewer days.
   - **You have been in the plan for more than** *90 days* **and live in a long-term care facility and need a supply right away.**

     We will cover one 34-day supply, or less if your prescription is written for fewer days.

Level of Care Changes

- If your level of care changes, we will cover a transition supply of your drugs. A level of care change happens when you are released from a hospital. It also happens when you move to or from a long-term care facility.
- If you move home from a long-term care facility or hospital and need a transition supply, we will cover one 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.

  If you move from home or a hospital to a long-term care facility and need a transition supply, we will cover one 34-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 34-day supply.

➔ To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

  There may be a different drug covered by our plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug even though it is not on the Drug List. Or you can ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

➔ To learn more about asking for an exception, see Chapter 9.

➔ If you need help asking for an exception, you can contact Member Services.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, we might make changes to the Drug List during the year. We might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.

- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We move your drug into a higher cost-sharing tier.
- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have an increase in your payments or added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, we must give you at least 60 days' notice about the change.
  - We may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - You and your provider can ask us to continue covering the brand-name drug for you. To learn how, see Chapter 9.
- If a drug is recalled because it is found to be unsafe or for other reasons, we will remove the drug from the Drug List. We will tell you about this change right away.
  - Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **we will send you a notice.** Normally, we will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by our plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a co-pay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage.

➔ To learn more about drug coverage and what you pay, see Chapter 6.

If you are in a long-term care facility

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

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long-term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a temporary supply of your drug during the first *90 days* of your membership, until we have given you a 102-day supply. The first supply will be for up to a 34-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first *90 days* in the plan.

If you have been a member of our plan for more than *90 days* and you need a drug that is not on our Drug List, we will cover one *34-day* supply. We will also cover one *34-day* supply if we have a limit on the drug's coverage. If your prescription is written for fewer than 34 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by our plan might work just as well for you. Or you and your provider can ask us to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

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

Programs to help members manage their drugs

We have programs for people who meet certain requirements for how much their total covered drug costs are, which medical conditions they have, and how many different drugs they take. These are called medication therapy management (MTM) programs.

A team of pharmacists and doctors developed the medication therapy management programs for us. The programs can help make sure our members are using the drugs that work best to treat their medical conditions. The programs also help members avoid potential drug-related problems.

Medication therapy management programs are voluntary and free to members. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

➔ If you have any questions about these programs, please contact Member Services.

Chapter 6: What you pay for your Medicare and Medi-Cal prescription drugs

Table of Contents

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, ***and***
- Drugs and items covered under Medi-Cal, ***and***
- Drugs and items covered by the plan as additional benefits.

Because you are eligible for Medi-Cal, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **Our *List of Covered Drugs.*** We call this the “Drug List.” It tells you:
  - » Which drugs we pay for
  - » Which of the 3 cost-sharing tiers each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at www.healthnet.com/calmediconnect. The Drug List on the website is always the most current.
- **Chapter 5 of this Member Handbook.** Chapter 5 tells how to get your outpatient prescription drugs through our plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **Our *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with us. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your *out-of-pocket costs*. This is the amount of money you, or others paying for you, pay for your prescriptions.
- Your *total drug costs.* This is the amount of money you, or others paying for you, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made since January 1.

➔ We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your total out-of-pocket costs. To find out which drugs our plan covers, see the Drug List.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to pay you back for our share of the cost of the drug.

Here are some times when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a co-pay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

➔ To learn how to ask us to pay you back for our share of the cost of the drug, see Chapter 7.

3. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, Health Net Cal MediConnect pays all of the costs of your Part D drugs for the rest of the year.

4. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under Health Net Cal MediConnect. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

Stage 1: Initial Coverage Stage	**Stage 2:** Catastrophic Coverage Stage
During this stage, **we pay part of the costs** of your drugs, and you pay your share. Your share is called the co-pay. You begin in this stage when you fill your first prescription of the year.	During this stage, **we pay all of the costs** of your drugs through December 31, 2014. You begin this stage when you have paid a certain amount of out-of-pocket costs.

D. Stage 1: The Initial Coverage Stage

During the Initial Coverage Stage, we pay a share of the cost of your covered prescription drugs, and you pay your share. Your share is called the *co-pay.* The co-pay depends on what cost-sharing tier the drug is in and where you get it.

Our cost-sharing tiers

Cost-sharing tiers are groups of drugs with the same co-pay. Every drug in the plan's Drug List is in one of 3 cost-sharing tiers. In general, the higher the tier number, the higher the co-pay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs have a low copay. They are generic drugs. The copay will be from $0.00 to $2.55. This depends on your level of Medi-Cal coverage.
- Tier 2 drugs have a higher copay. They are brand name drugs. The copay will be from $0.00 to $6.35. This depends on your level of Medi-Cal coverage.
- Tier 3 drugs have a copay of $0.00. They are prescription and Over-the-counter (OTC) drugs that Medi-Cal covers.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network pharmacy, ***or***
- An out-of-network pharmacy.

➔ In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5 to find out when we will do that.

➔ To learn more about these pharmacy choices, see Chapter 5 in this handbook and our *Provider and Pharmacy Directory.*

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5 or the *Provider and Pharmacy Directory.*

How much do you pay?

During the Initial Coverage Stage, you may pay a co-pay each time you fill a prescription. If your covered drug costs less than the co-pay, you will pay the lower price.

➔ You can contact Member Services to find out how much your co-pay is for any covered drug.

Your share of the cost when you get a *one-month or long-term* supply of a covered prescription drug from:

	A network pharmacy A one-month or up to a 30-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 34-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Cost-sharing Tier 1 (Part D Generic Drugs)	$0.00 to $2.55 This depends on your level of Medi-Cal coverage.	$0.00 to $2.55 This depends on your level of Medi-Cal coverage.	$0.00 to $2.55 This depends on your level of Medi-Cal coverage.	$0.00 to $2.55 This depends on your level of Medi-Cal coverage.
Cost-sharing Tier 2 (Part D Brand Drugs)	$0.00 to $6.35 This depends on your level of Medi-Cal coverage	$0.00 to $6.35 This depends on your level of Medi-Cal coverage	$0.00 to $6.35 This depends on your level of Medi-Cal coverage	$0.00 to $6.35 This depends on your level of Medi-Cal coverage
Cost-sharing Tier 3 (Prescription and OTC drugs that Medi-Cal covers.)	$0.00	$0.00	$0.00	$0.00

➔ For information about which pharmacies can give you long-term supplies, see our *Provider and Pharmacy Directory.*

When does the Initial Coverage Stage end?

The Initial Coverage Stage ends when your total out-of-pocket costs reach $4,550. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your Explanation of Benefits reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the $4,550 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of $4,550 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

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

When you get less than a month's supply of a drug, your co-pay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the co-pay for your drug for a full month's supply (a 30-day supply) is $1.20. This means that the amount you pay per day for your drug is $0.04. If you receive a 7 days' supply of the drug, your payment will be $0.04 per day multiplied by 7 days, for a total payment of $0.28.
- You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after

your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $0.04 per day, or $0.92. Your total cost for the month will be $0.28 for your first prescription and $0.92 for your second prescription, for a total of $1.20 – the same as your co-pay would be for a full month's supply.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

G. Prescription Cost-sharing Assistance for Persons with HIV/AIDS

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ensure that eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Office of AIDS for individuals enrolled in ADAP.

Not enrolled in ADAP?

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 888-311-7632 or go to the ADAP pharmacy benefits manager, Ramsell Public HealthRx, website at http://www.ramsellcorp.com/individuals/ca.aspx.

Already enrolled in ADAP?

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. If you need assistance finding the nearest ADAP enrollment site and/or enrollment worker, please call 888-311-7632 or go to the website listed above.

H. Vaccinations

We cover Medicare Part D vaccines. What you pay for vaccinations (shots) covered by Medicare Part D depends on how and where you get them.

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

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.

2. The second part of coverage is for the cost of **giving you the shot**.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Health Net Cal MediConnect to ensure that you do not have any upfront costs for a Part D vaccine.

If you are not able to use a network provider and pharmacy, you may have to pay the entire cost for both the vaccine itself and for getting the shot. If you are in this situation, we recommend that you call us first at Member Services. You can also ask the provider to call Health Net Cal MediConnect before you get your vaccine. If you pay the full cost of the vaccine at a provider's office, we can tell you how to ask us to pay you back for our share of the cost.

➔ To learn how to ask us to pay you back, see Chapter 7.

How much you pay for a Medicare Part D vaccination

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

1. The type of vaccine (what you are being vaccinated for)
   - Some vaccines are considered health benefits rather than drugs. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4.
   - Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List.
2. Where you get the vaccine itself
3. Who gives you the shot

Sometimes you will have to pay the entire cost for both the vaccine itself and for getting the shot. You can ask us to pay you back for our share of the cost. Other times, you will pay only your share of the cost.

➔ To learn how to ask us to pay you back, see Chapter 7.

Here are three common ways you might get a Medicare Part D vaccination.

1. You buy the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a co-pay for the vaccine.
   - We will pay for the cost of giving you the shot.
2. You get the Medicare Part D vaccination at your doctor's office.
   - When you get the vaccination, you will pay for the vaccine and for getting the shot.
   - You can then ask our plan to pay you back for our share of the cost. To learn how to ask us to pay you back, see Chapter 7.
3. You buy the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
   - You will pay a co-pay for the vaccine.
   - When your doctor gives you the shot, you will pay the entire cost for the service. You can then ask us to pay you back. To learn how to ask us to pay you back, see Chapter 7.

Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs

Table of Contents

A. When you can ask us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs already received. A *network provider* is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, see page 127.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, we will pay you back. It is your right to be paid back if you paid more than your share of the cost for the services or drugs.
- If the services or drugs are **not** covered, we will tell you.

➔ Contact Member Services if you have any questions. If you do not know what you should have paid, or if you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. When you get emergency or urgently needed health care from an out-of-network provider

You should ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
  - » If the provider should be paid, we will pay the provider directly.
  - » If you have already paid more than your share of the cost for the service, we will figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us.

- We do not allow providers to add separate charges, called “balance billing.” This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you do not have to pay them.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and take care of the problem.

- If you have already paid a bill from a network provider, but you feel that you paid too much, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

➔ In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost. Please see Chapter 5 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your plan ID card with you

If you do not have your plan ID card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on our *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - » If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9).
  - » If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

➔ To learn how to make an appeal, see Chapter 9.

B. How and where to send us your request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your care coordinator for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.healthnet.com/calmediconnect), or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to us at this address:

Medical Claims address:

For Cal MediConnect:
Health Net of California
P.O. Box 14703
Lexington, KY 40512

Pharmacy Claims address:

Health Net
Attn: Pharmacy Claims
PO Box 419069
Rancho Cordova, CA 95741-9069

You must submit your claim to us within one calendar year (for medical claims) and within 3 years (for drug claims) of the date you got the service, item, or drug.

C. We will make a coverage decision

When we get your request for payment, we will make a *coverage decision.* This means that we will decide whether your health care or drug is covered by our plan. We will also decide the amount of money, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the

service or drug, we will mail you a check for our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.

➔ Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

  ➔ To learn more about coverage decisions, see Chapter 9.

D. You can make an appeal

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called *making an appeal.* You can also make an appeal if you do not agree with the amount we pay.

➔ The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9.

- If you want to make an appeal about getting paid back for a health care service, go to page 173.
- If you want to make an appeal about getting paid back for a drug, go to page 182.

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. You have a right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages. You can also get this information handbook in the following languages for free:

- Spanish
- Vietnamese
- Chinese
- Russian
- Tagalog
- Korean
- Farsi
- Cambodian

➔ To get this information in other languages, call 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week. We can also give you information in Braille, audio, or large print.

➔ If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. For information on filing a complaint with Medi-Cal, please contact Member Services at 1-855-464-3571 (TTY: 711). You can call 24 hours a day, seven days a week.

Le explicaremos los beneficios de su plan y sus derechos de una manera que usted pueda comprender. Le explicaremos sus derechos cada año de cobertura de nuestro plan.

Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios al Afiliado. Nuestro plan cuenta con personas que pueden responder a sus preguntas en varios idiomas. También puede obtener este manual de manera gratuita en los siguientes idiomas:

- Español
- Vietnamita
- Chino
- Ruso
- Tagalo
- Coreano
- Persa
- Camboyano
- Árabe

➔ Para recibir esta información en otros idiomas, llame al 1-855-464-3571 (TTY: 711) las 24 horas del día, los 7 días de la semana. También podemos proporcionarle información en Braille, en formato de audio o en letra grande.

➔ Si tiene dificultades para obtener información de parte de nuestro plan por problemas relacionados con el idioma o una discapacidad y desea presentar una queja, comuníquese con Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. Para obtener información sobre cómo presentar una queja ante Medi-Cal, comuníquese con el Departamento de Servicios al Afiliado al 1-855-464-3571 (TTY: 711). Puede llamar las 24 horas del día, los 7 días de la semana.

Chúng tôi phải cho quý vị biết về các phúc lợi trong chương trình và quyền của quý vị theo cách mà quý vị có thể hiểu được. Chúng tôi phải cho quý vị biết về các quyền của quý vị vào mỗi năm mà quý vị tham gia chương trình của chúng tôi.

Để nhận thông tin theo cách thức quý vị có thể hiểu được, hãy gọi cho bộ phận Dịch Vụ Thành Viên. Chương trình của chúng tôi có những người có thể trả lời các câu hỏi của quý vị bằng các ngôn ngữ khác nhau. Quý vị cũng có thể nhận miễn phí sổ tay này bằng các ngôn ngữ dưới đây

Tiếng Tây Ban Nha	Tiếng Tagalog
Tiếng Việt	Tiếng Hàn Quốc
Tiếng Trung Quốc	Tiếng Ba Tư
Tiếng Nga	Tiếng Cam-pu-chia

- Để nhận thông tin này bằng các ngôn ngữ khác, hãy gọi 1-855-464-3571 (TTY: 711) 24 giờ một ngày, bảy ngày một tuần. Chúng tôi cũng có thể cung cấp thông tin cho quý vị bằng nổi Braille, dưới dạng âm thanh hoặc bản in cỡ lớn.
- Nếu quý vị đang gặp khó khăn với việc tiếp nhận thông tin từ chương trình của chúng tôi do các vấn đề về ngôn ngữ hoặc do khuyết tật và quý vị muốn nộp đơn khiếu nại, hãy gọi cho Medicare theo số 1-800-MEDICARE (1-800-633-4227). Quý vị có thể gọi 24 giờ một ngày, bảy ngày một tuần. Người dùng TTY cần gọi số 1-877-486-2048. Để biết thông tin về việc nộp đơn khiếu nại với Medi-Cal, vui lòng liên lạc với bộ phận Dịch Vụ Thành Viên theo số 1-855-464-3571 (TTY: 711). Quý vị có thể gọi 24 giờ một ngày, bảy ngày một tuần.

我們必須以您能夠理解的方式告訴您本計畫的給付及您的權利。您加入我們健保計畫的每一年，我們都必須告知您的權利。

欲以您能夠理解的方式取得資訊，請致電會員服務部。本計畫配備的工作人員能夠以不同的語言回答問題。您也可以免費取得本手冊以下語言版本

- 西班牙語
- 越南語
- 中文
- 俄語
- 菲律賓語
- 韓語

- 波斯語
- 阿拉伯語
- 柬埔寨語

➔ 欲取得本資訊其他語言版本， 1-855-464-3571 (TTY: 711)，每天 24 小時，每週 7 天均提供服務。我們也以盲文點字、音訊或大字版提供本資訊。

➔ 如果您因語言問題或殘障而在取得資訊時遭遇麻煩而想要提出申訴，請致電 Mediare, 電話 1-800-MEDICARE (1-800-633-4227)。您可以全天候撥打，每天 24 小時，每週 7 天均提供服務。TTY 用戶應撥打 1-877-486-2048。欲知向 Medi-Cal 提出申訴方面的資訊，請聯絡會員服務部 1-855-464-3571 (TTY: 711). 您可以全天候撥打，每天 24 小時，每週 7 天均提供服務。

Мы должны объяснять вам, какие услуги (бенефиты) план покрывает и какие у вас есть права. Наши объяснения должны быть понятными. Пока вы остаетесь в нашем плане, мы должны каждый год объяснять вам ваши права.

За понятными объяснениями обращайтесь в наш отдел обслуживания. Сотрудники нашего плана говорят на многих языках. Кроме того, вы можете бесплатно получить этот справочник на следующих языках:

- Испанский
- Корейский
- Вьетнамский
- Фарси
- Китайский
- Камбоджийский
- Русский
- Арабский
- Тагальский

➔ Если информация вам нужна на других языках, позвоните нам, телефон 1-855-464-3571 (TTY: 711); линия работает круглосуточно и без выходных. Кроме того, мы можем присылать вам информацию, напечатанную шрифтом Брайля или крупным шрифтом.

➔ Если плохое знание языка или ограниченность физических возможностей затрудняет понимание информации, предоставляемой нашим планом, вы можете подать жалобу. Для этого позвоните в программу Medicare по телефону 1-800-MEDICARE (1-800-633-4227). Звонить по этому телефону можно круглосуточно и без выходных. Если вы пользуетесь линией TTY, звоните по телефону 1-877-486-2048. О том как подать жалобу в программу Medi-Cal, вам расскажут сотрудники отдела обслуживания, телефон 1-855-464-3571 (TTY: 711). Линия работает круглосуточно и без выходных.

Dapat namin sabihin sa inyo ang tungkol sa mga benepisyo ng plano at ang inyong mga karapatan sa paraan na mauunawaan ninyo. Dapat namin sabihin sa inyo ang tungkol sa inyong mga karapatan bawa't taon na kayo ay nasa plano namin.

Upang makakuha ng impormasyon sa paraan na mauunawaan ninyo, tawagan ang Mga Serbisyo sa Miyembro (Member Services). Ang aming plano ay mayroong mga tao na maaaring masagot ang mga katanungan sa iba't-ibang mga wika. Maaari rin ninyo makuha nang libre ang handbook na ito sa mga sumusunod na wika

- Espanyol
- Vietnamese
- Chinese
- Russian
- Tagalog
- Korean
- Farsi
- Cambodian

➔ Upang makuha ang impormasyon na ito sa ibang mga wika tawagan ang 1-855-464-3571 (TTY: 711) 24 oras sa isang araw, pitong araw sa isang linggo. Maaari rin namin kayo bigyan ng impormasyon na nasa Braille, audio, o malaking letra.

➔ Kung nahihirapan kayo makakuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto ninyong magsampa ng isang reklamo, tawagan ang Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kayong tumawag nang 24 oras sa isang araw, pitong araw sa isang linggo. Ang mga gumagamit ng TTY ay dapat tawagan ang 1-877-486-2048. Para sa impormasyon sa pagsampa ng isang reklamo sa Medi-Cal, mangyaring makipag-ugnayan sa Member Services sa 1-855-464-3571 (TTY: 711). Maaari kayong tumawag nang 24 oras sa isang araw, pitong araw sa isang linggo.

당사는 반드시 귀하께서 이해하실 수 있는 방법으로 보험 플랜의 혜택과 귀하의 권리를 알려드려야 합니다. 또한 귀하께서 당사의 보험 플랜에 가입해 있는 한 매년 반드시 귀하의 권리를 공지해 드려야 합니다.

귀하께서 이해하실 수 있는 방법으로 정보를 얻으시려면 회원서비스부로 전화해 주십시오. 여러 다른 언어로 질문에 답변해 드릴 수 있는 직원이 근무하고 있습니다. 또한 다음 언어로 된 본 안내서를 무료를 받으실 수 있습니다.

- 스페인어
- 베트남어
- 중국어
- 러시안어
- 타갈로그어
- 한국어
- 페르시아어
- 캄보디아어

➔ 본 정보를 다른 언어로 받으시려면 연중무휴 24 시간 운영되는 1-855-464-3571 (TTY: 711)번으로 전화해 주십시오. 당사는 또한 점자, 오디어 또는 대형 인쇄체로 정보를 제공할 수 있습니다.

➔ 언어 문제 또는 장애로 인해 당사 보험 플랜으로부터 정보를 얻는데 곤란을 겪고 있어 불만을 제기하고 싶으시면 1-800-MEDICARE (1-800-633-4227)로 Medicare 에 전화해 주십시오. 연중무휴 24 시간 운영되므로 항시 전화하실 수 있습니다. TTY 사용자는 1-877-486-2048 번으로 전화하실 수 있습니다. Medi-Cal 에 불만을 제기하는 것에 관한 정보는 1-855-464-3571 (TTY: 711)번으로 회원서비스부에 전화해 주십시오. 연중무휴 24 시간 운영되므로 항시 전화하실 수 있습니다.

ما باید اطلاعاتی در مورد مزایای برنامه و حقوق قانونی شما را به روشی که درک می کنید در اختیار شما قرار دهیم. ما باید برای هر سالی که در برنامه درمانی ما عضویت دارید اطلاعاتی را در مورد حقوق قانونی شما در اختیارتان قرار دهیم.

برای کسب اطلاعات به روشی که بتوانید درک کنید، با خدمات اعضا تماس بگیرید. برنامه ما اشخاصی را در استخدام دارد که می توانند به سؤالات به زبان های گوناگون پاسخ دهند. همچنین می توانید این دفترچه را به طور رایگان به زبان های زیر دریافت کنید.

- تاگولوگ
- کره ای
- فارسی
- کامبوجی
- اسپانیایی
- ویتنامی
- چینی
- روسی

- برای دریافت این اطلاعات به زبان های دیگر در 24 ساعت شبانروز و هفت روز هفته در 1-855-464-3571 تماس بگیرید (TTY: 711). ما می توانیم اطلاعاتی را به صورت بریل، صوتی یا چاپ درشت در اختیار شما قرار دهیم.
- اگر به خاطر مشکلات زبانی یا معلولیت در دریافت اطلاعات از برنامه ما با مشکلاتی مواجه هستید و می خواهید شکایتی را تسلیم کنید، با Medicare به شماره 1-800-MEDICARE (1-800-633-4227) تماس بگیرید. می توانید در 24 ساعت شبانروز و هفت روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند. برای اطلاعات مربوط به تسلیم شکایت به Medi-Cal، لطفاً با خدمات اعضا در 1-855-464-3571 تماس بگیرید (TTY: 711). می توانید در 24 ساعت شبانروز و هفت روز هفته تماس بگیرید.

យើងត្រូវតែប្រាប់អ្នកអំពីផលប្រយោជន៍របស់ផែនការនេះ
និងសិទ្ធិ៍របស់អ្នកក្នុងវិធីមួយដែលអ្នកអាចយល់បាន ។ យើងត្រូវតែប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នក
រាល់ឆ្នាំនីមួយៗដែលអ្នកស្ថិតក្នុងផែនការរបស់យើង ។

ដើម្បីទទួលបានព័ត៌មានក្នុងវិធីមួយដែលអ្នកអាចយល់បាន ហៅទូរស័ព្ទទៅផ្នែកសេវាសមាជិក ។
ផែនការរបស់យើងមានមនុស្សដែលអាចឆ្លើយសំណួរនានាជាភាសាផ្សេងៗបាន ។
អ្នកក៏អាចទទួលបានសៀវភៅណែនាំអ្នកប្រើប្រាស់នេះជាភាសាដូចខាងក្រោមដោយឥតគិតថ្លៃ

- ភាសាអេស្ប៉ាញ
- ភាសាវៀតណាម
- ភាសាចិន
- ភាសារុស្ស៊ី
- ភាសាកូរ៉េ
- ភាសាហ្មាស៊ី
- ភាសាខ្មែរ
- ភាសាតាហ្គាឡុក

➔ ដើម្បីទទួលបានព័ត៌មានជាភាសាផ្សេងទៀត សូមហៅទូរស័ព្ទទៅ 1-855-464-3571 (TTY: 711) 24 ម៉ោងក្នុងមួយថ្ងៃ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ ។ យើងក៏អាចផ្តល់ព័ត៌មានឱ្យអ្នកជាអក្សរសម្រាប់ជនពិការជាសម្លេង ឬ អក្សរពុម្ពធំផងដែរ ។

➔ ប្រសិនបើអ្នកកំពុងមានបញ្ហាជាមួយការទទួលបានព័ត៌មានពីផែនការរបស់យើង ដោយសារតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់រៀបចំបណ្តឹង ហៅទូរស័ព្ទទៅកាន់ Medicare តាមរយៈលេខ 1-800-MEDICARE (1-800-633-4227) ។ អ្នកអាចហៅទូរស័ព្ទ 24 ម៉ោងក្នុងមួយថ្ងៃ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ ។ អ្នកប្រើប្រាស់ TTY គួរតែហៅទូរស័ព្ទទៅលេខ 1-877-486-2048 ។ សម្រាប់ព័ត៌មានស្តីពីការរៀបចំបណ្តឹងជាមួយ Medi-Cal សូមទាក់ទងផ្នែកសេវាសមាជិកនៅ 1-855-464-3571 (TTY: 711) ។ អ្នកអាចហៅទូរស័ព្ទ 24 ម៉ោងក្នុងមួយថ្ងៃ ប្រាំពីរថ្ងៃក្នុងមួយសប្តាហ៍ ។

B. We must treat you with respect, fairness, and dignity at all times

We must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Race
- Ethnicity
- National origin
- Religion
- Sex
- Sexual orientation
- Age
- Mental ability
- Behavior
- Mental or physical disability
- Health status
- Receipt of health care
- Use of services
- Claims experience
- Appeals
- Medical history
- Genetic information
- Evidence of insurability
- Geographic location within the service area

Under the rules of our plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.

We cannot deny services to you or punish you for exercising your rights.

➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also call your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697

➔ If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. We must ensure that you get timely access to covered services and drugs

If you cannot get an appointment to receive covered services within the appointment wait times because the provider does not have any appointments available or because there are only a limited number of in-network providers within your service area available to perform the recommended service or treatment, and your treating or referring doctor/provider does not think you can wait a longer period of time for the appointment, you can call Health Net's Cal MediConnect Member Services Department at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week, and they can assist you. The member services representative will contact your medical group to determine if the medical group will locate and/or authorize a visit to another provider in a neighboring area or a provider outside of the network, if there are no contracted providers within your service area that can provide the appointment timely. If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in our network. A *network provider* is a provider who works with us.
  - » Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- Women have the right to go to a gynecologist or another women's health specialist without getting a referral. A *referral* is a written order from your primary care provider.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - » This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3.

- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 6 months for Medicare services and up to 12 months for Medi-Cal services if certain criteria are met. To learn more about keeping your providers and service authorizations, see Chapter 1.
- You have the right to hire, fire, and manage your In-Home Services and Supports (IHSS) worker.
- You have the right to self-direct care with help from your care team and care coordinator.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights and also explains how we protect the privacy of your health information. The notice is called the “Notice of Privacy Practice.”

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to release health information by court order.

» We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to federal laws. If we share your information with Medi-Cal, as appropriate, it will also be done according to federal and state law.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

E. We must give you information about our plan, our network providers, and your covered services

As a member of Health Net Cal MediConnect, you have the right to get information from us. If you do not speak English, we have interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-855-464-3571 (TTY: 711) 24 hours a day, seven days a week. This is a free service to you. You can also get this handbook in the following languages for free:

- Spanish
- Vietnamese
- Chinese
- Russian
- Tagalog
- Korean
- Farsi
- Cambodian

We can also give you information in Braille, audio, or large print.

If you want any of the following, call Member Services:

- **Information about how to choose or change plans**
- **Information about our plan, including:**
  - » Financial information
  - » How we have been rated by plan members
  - » The number of appeals made by members
  - » How to leave our plan
- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change primary care providers
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network
- **Information about covered services and drugs and about rules you must follow, including:**
  - » Services and drugs covered by our plan
  - » Limits to your coverage and drugs
  - » Rules you must follow to get covered services and drugs
- **Information about why something is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made
  - » Asking us to pay for a bill you have received

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay less than the provider charged. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7.

G. You have the right to leave our Cal MediConnect plan at any time

No one can make you stay in our plan if you do not want to. You can leave our plan at any time. If you leave our plan, you will still be in the Medicare and Medi-Cal programs. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. Your Medi-Cal benefits will continue to be offered through Health Net Community Solutions, Inc. unless you choose a different plan available in this county.

Please see Chapter 10 for more information on leaving our plan.

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **You can say "no.**" You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, you will not be dropped from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You can ask us to cover a service or drug that was denied or is usually not covered.** Chapter 9 tells how to ask the plan for a coverage decision.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a *living will* and a *power of attorney for health care*.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, a social worker, from the California Medical Association by calling 1-800-882-1262 (National Relay Service: 711), or from some office supply stores. Organizations that give people information about Medicare or Medi-Cal, such as HICAP (Health Insurance and Counseling Advocacy Program) may also have advance directive forms.
- **Fill it out and sign the form.** The form is a legal document. It must be notarized or witnessed by two qualified individuals. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

California: Physician Orders for Life Sustaining Treatment (POLST)

You may also consider completing a POLST form if you are terminally ill or in frail health. This form must be signed by your physician and allows you to give specific end-of-life treatment instructions, such as for pain management, resuscitation, feeding procedures and other medical interventions. It has the force of a physician's medical order and remains with you wherever you receive care. It is in addition to, and does not replace, an advance directive.

What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

The telephone number is 1-800-368-1019 or 1-415-437-8310 (TDD: 1-800-537-7697)

Please be aware of the following:

- If you have executed an advance directive, Health Net is required to make sure that it is documented in a prominent part of your current medical record.
- Health Net is required to comply with State law on advance directives.
- Health Net must educate its staff about its policies and procedures for advance directives.

Health Net must provide for community education regarding advance directives.

I. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 138—you can get help in these ways:

- You can **call Member Services**.

- You can **call your local Health Insurance Counseling and Advocacy Program (HICAP) program**. For details about this organization and how to contact it, see Chapter 2.
- You can **call the Cal MediConnect Ombuds Program**. For details about this organization and how to contact it, see Chapter 2.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Member Services**.
- You can **call your local Health Insurance Counseling and Advocacy Program (HICAP) program**. For details about this organization and how to contact it, see Chapter 2.
- You can **call the Cal MediConnect Ombuds Program**. For details about this organization and how to contact it, see Chapter 2.
- You can **contact Medicare**.
  - » You can visit the Medicare website to read or download “Medicare Rights & Protections.” (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

J. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
  - » For details about your covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage you have.** Please call Member Services to let us know.

» We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits.*

» For more information about coordination of benefits, see Chapter 1.

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan ID card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
  - » Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - » Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - » If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - » Medicare Part A and Medicare Part B premiums. For most Health Net Cal MediConnect members, Medi-Cal pays for your Part A premium and your Part B premium.
  - » For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a co-pay (a fixed amount). Chapter 6 tells what you must pay for your drugs.
  - » If you get any services or drugs that are not covered by our plan, you must pay the full cost.

  ➔ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1 tells about our service area. We can help you figure out whether you are moving outside our service area. During a special enrollment period, you

can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medi-Cal know your new address when you move. See Chapter 2 for phone numbers for Medicare and Medi-Cal.

» **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

Call Member Services for help if you have questions or concerns.

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

What's in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Nursing Facility (NF) services.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

You should receive the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. If you are having a problem with your care, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077 for help. This number will be available after April 1, 2014. This chapter will explain the different options you have for different problems and complaints, but you can always call the Cal MediConnect Ombuds Program to help guide you through your problem.

Table of Contents

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medi-Cal. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Cal MediConnect Ombuds Program

If you need help getting started, you can always call the Cal MediConnect Ombuds Program. The Cal MediConnect Ombuds Program can answer your questions and help you understand what to do to handle your problem. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. This number will be available after April 1, 2014. The services are free.

You can get help from the Health Insurance Counseling and Advocacy Program (HICAP)

You can also call the Health Insurance Counseling and Advocacy Program (HICAP). The HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The local HICAP phone number is 1-213-383-4519, Within L.A. County: 1-800-824-0780.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.
- Visit the Medicare website (http://www.medicare.gov).

Getting help from Medi-Cal

You can call the Cal MediConnect Ombuds Program directly for help with problems with Medi-Cal. The phone number is 1-855-501-3077. This number will be available after April 1, 2014.

You can also visit the Office of the Patient Advocate website (http://www.opa.ca.gov).

You can get help from the California Department of Managed Health Care

The following paragraph is a required disclosure under California Health & Safety Code Section 1368.02(b). In this paragraph, the term "grievance" means an appeal or complaint about Medi-Cal services.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Section 3: Problems with your Benefits

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, long-term services and supports, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go to the next section of this chapter,	**No.** My problem is <u>not</u> about benefits or coverage. Skip ahead to **Section 10** at the end of

Section 4, "Coverage decisions and appeals."	this chapter: **"How to make a complaint."**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment. You are not responsible for Medicare costs except Part D co-pays.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medi-Cal, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medi-Cal. If you or your doctor disagree with our decision, you can appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- You can call us at **Member Services** at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. The phone number is 1-855-501-3077. This number will be available after April 1, 2014.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-213-383-4519, Within L.A. County: 1-800-824-0780.
- Call your **local county social services office** for questions about coverage decisions for In-Home Supportive Services (IHSS). The phone number is 1-888-678-4477 (TTY: 711).

- Call the **Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people enrolled in Cal MediConnect with appeals about Medi-Cal services. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - » If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.healthnet.com/calmediconnect. The form will give the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** gives you information if you have problems about services, items, and drugs (but not Part D drugs). For example, use this section if:
  - o You are not getting medical care you want, and you believe that this care is covered by our plan.
  - o We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered.
    - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with an "NT" are not covered by Part D. See Section 6 for Part D drug appeals.

- You received medical care or services that you think should be covered, but we are not paying for this care.
- You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
  - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.
- You are being told your In-Home Supportive Services (IHSS) hours will be reduced.

- **Section 6** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
  - You want to ask us to waive limits on the amount of the drug you can get.
  - You want to ask us to cover a drug that requires prior approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
  - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should be using, please call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. You can also get help or

information from the Cal MediConnect Ombuds Program by calling 1-855-501-3077. This number will be available after April 1, 2014.

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term services and supports (LTSS). You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with an "NT" are not covered by Part D. Use Section 6 for Part D drug Appeals.

This section tells what you can do if you are in any of the following situations:

1. **You think the plan covers medical, behavioral health, or long-term services and supports (LTSS) that you need but are not getting.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 162) for information on asking for a coverage decision.

2. **The plan did not approve care your doctor wants to give you, and you think it should have.**

   What you can do: You can appeal the plan's decision to not approve the care. Go to Section 5.3 (page 164) for information on making an appeal.

3. **You received services or items that you think the plan covers, but the plan will not pay.**

   What you can do: You can appeal the plan's decision not to pay. Go to Section 5.4 (page 167) for information on making an appeal.

4. **You got and paid for medical services or items you thought were covered, and you want the plan to reimburse you for the services or items.**

   What you can do: You can ask the plan to pay you back. Go to Section 5.6 (page 173) for information on asking the plan for payment.

5. **Your coverage for a certain service is being reduced or stopped, and you disagree with our decision.**

   What you can do: You can appeal the plan's decision to reduce or stop the service.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation

Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

➔ In all cases where we tell you that medical care you have been getting will be stopped, use the information in Section 5.2 of this chapter as your guide for what to do.

6. Your In-Home Supportive Services (IHSS) hours were denied or reduced, and you disagree with the decision.

What you can do: You can appeal the county's decision to deny or reduce IHSS hours by requesting a State Fair Hearing.

➔ IHSS hours are determined by your county social worker, not our plan. The county social worker will assess the types of services you need and the number of hours the county will authorize for each of these services. If you have questions regarding your IHSS hours, go to Section 5.5 of this chapter.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get medical, behavioral health, or certain long-term services and supports (MSSP, CBAS, or NF services)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- You can fax us at: 1-800-281-2999
- You can to write us at:

  Health Net Cal MediConnect

  P.O. Box 10422

  Van Nuys, CA 91410-0422

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you asked. If we don't give you our decision within 14 calendar days, you can appeal.

➔ Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 72 hours**.

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days.

> ***The legal term*** *for "fast coverage decision" is* ***"expedited determination."***

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week, or fax us at 1-800-281-2999. For the details on how to contact us, go to Chapter 2, page 15.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking for coverage for care or an item *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for care or an item you have already received.)
- You can get a fast coverage decision *only* if the standard 14-calendar-day deadline could *cause serious harm to your health or hurt your ability to function.*
  - ➔ **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
  - ➔ If you ask for a fast coverage decision, without your doctor's support, we will decide if you get a fast coverage decision.
    - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14-calendar-day deadline instead.
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast

coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If the coverage decision is *Yes*, when will I get the service or item?

You will be able to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, we will send you a letter telling you our reasons for saying *No*.

- If we say no, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagrees with our decision, you can appeal.

In most cases, you must start your appeal at Level 1.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

NOTE: You are not required to appeal to the plan for Medi-Cal services, including long-term services and supports. If you do not want to first appeal to the plan, you can ask for a State Fair Hearing or, in special cases, an Independent Medical Review. Go to page168 for more information.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. For additional details on how to reach us for appeals, see Chapter 2, page 15.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
  - You can submit a written request to the following address:

    Health Net Cal MediConnect

    P.O. Box 10422

    Van Nuys, CA 91410-0422
  - You can submit your request online at: https://www.healthnet.com/portal/member/content/iwc/member/unprotected/health_plan/content/file_ag_duals.action
  - You may also ask for an appeal by calling us at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- You will receive a letter from us within 5 calendar days of receiving your appeal letting you know that we received it.

> ***The legal term*** *for “fast appeal” is* ***“expedited reconsideration.”***

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or our website at www.healthnet.com/calmediconnect.

➔ If the appeal comes from someone besides you or your doctor or other provider, we must receive the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal within 90 calendar days from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

Can I get a copy of my case file?

Yes. Ask us for a copy.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will the plan make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said *No* to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" appeal decision?

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you by letter.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- If we do not give you an answer within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a Medicare service or item. You will be notified when this happens. If your problem is about a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

What happens if I ask for a fast appeal?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you by letter.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), we will automatically send your case to Level 2 of the appeals process if your problem is about a Medicare service or item. You will be notified when this happens. If your problem is about a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

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

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section 5.4 of this chapter.

Will my benefits continue during Level 1 appeals?

During a Level 1 Appeal, you can keep getting all prior approved non-Part D benefits that we told you would be stopped or changed. This means that such benefits will continue to be provided to you and that we must continue to pay providers for providing such benefits during a Level 1 Appeal.

Section 5.4: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says *No* at Level 1, what happens next?

If we say no to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare or Medi-Cal.

- If your problem is about a **Medicare** service or item, we will automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.

- If your problem is about a **Medi-Cal** service or item, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to the plan. It is either an Independent Review Entity (IRE) or it is a Medi-Cal office.

My problem is about a Medi-Cal service or item. How can I make a Level 2 Appeal?

There are two ways to make a Level 2 appeal for Medi-Cal services and items: 1) State Fair Hearing or 2) Independent Medical Review (IMR).

1) State Fair Hearing

You can request a State Fair Hearing at any time for Medi-Cal covered services and items (including IHSS). If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have, you have the right to ask for a State Fair Hearing.

In most cases you have 90 days to ask for a State Fair Hearing after the “Your Hearing Rights” notice is mailed to you. You have a much shorter time to ask for a hearing if your benefits are being changed or taken away.

There are two ways to request a State Fair Hearing:

1. You may complete the "Request for State Fair Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
    - To the county welfare department at the address shown on the notice.
    - To the California Department of Social Services:

      State Hearings Division
      P.O. Box 944243, Mail Station 9-17-37
      Sacramento, California 94244-2430

    - To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.
2. You may make a toll-free call to request a State Fair Hearing at the following number. If you decide to make a request by phone, you should be aware that the phone lines are very busy.
    - Call the California Department of Social Services at 1-800-952-5253. TDD users should call 1-800-952-8349.

2) Independent Medical Review (IMR)

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items that are medical in nature (not including IHSS).

An IMR is a review of your case by doctors who are not part of our plan. IMRs are conducted by the Help Center at the California Department of Managed Health Care (DMHC). You pay no costs for an IMR. You pay no costs for an IMR.

You can apply for an IMR if Health Net Cal MediConnect:

- Denies, changes, or delays a Medi-Cal service or treatment (not including IHSS) because Health Net Cal MediConnect determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.

You cannot ask for an IMR if you already had a State Fair Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. See page 164 for information about Health Net Cal Medi Connect's Level 1 appeal process. If you disagree with our decision, you can ask the DMHC Help Center for an IMR.

- ➔ If your treatment was denied because it was experimental or investigational, you do not have to take part in Health Net Cal MediConnect's appeal process before you apply for an IMR.
- ➔ If your problem is urgent and involves an immediate and serious threat to your health, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you first follow Health Net Cal MediConnect's appeal process in extraordinary and compelling cases.

You must apply for an IMR within 6 months after we send you a written decision about your appeal. The DMHC may accept your application after 6 months if it determines that circumstances kept you from submitting your application in time.

To request an IMR:

- Fill out the Complaint/Independent Medical Review (IMR) Application Form available at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx or call the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.

- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx or by calling the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891
- Mail or fax your form and any attachments to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: 916-255-5241

For non-urgent cases involving Medi-Cal services (not including IHSS), you will receive an IMR decision from the DMHC within 30 days of receipt of your application and supporting documents. For urgent cases that involve an immediate or serious risk to your health, you will receive an IMR decision within 3 to 7 days.

If the IMR is decided in your favor, we must give you the service or item you requested. If you are not satisfied with the result of the IMR, you can still ask for a State Fair Hearing.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be notified when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file.

➔ The Independent Review Entity must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

  » However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

- If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The review organization must give you an answer within 72 hours of when it gets your appeal.
  - » However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

Will my benefits continue during Level 2 appeals?

If your problem is about a service or item covered by Medicare, your benefits for that service or item will not continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medi-Cal and you ask for a State Fair Hearing, your Medi-Cal benefits for that service or item will continue until a hearing decision is made. You must ask for a hearing before the date that your benefits are changed or taken away in order to get the same benefits until your hearing.

How will I find out about the decision?

If your Level 2 Appeal was a State Fair Hearing, the California Department of Social Services will send you a letter explaining its decision.

- If the State Fair Hearing decision is *Yes* to part or all of what you asked for, we must comply with the decision. We must complete the described action(s) within 30 calendar days of the date we received a copy of the decision.
- If the State Fair Hearing decision is *No* to part or all of what you asked for, it means they agree with the Level 1 decision. We may stop any aid paid pending you are receiving.

If your Level 2 Appeal was an Independent Medical Review, the Department of Managed Health Care will send you a letter explaining its decision.

- If the Independent Medical Review decision is *Yes* to part or all of what you asked for, we must provide the service or treatment.
- If the Independent Medical Review decision is *No* to part or all of what you asked for, it means they agree with the Level 1 decision. You can still get a State Fair Hearing. Go to page 168 for information about asking for a State Fair Hearing.

If your Level 2 Appeal went to the Medicare Independent Review Entity, it will send you a letter explaining its decision.

- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we receive the IRE's decision.

➔ If the Independent Review Entity says *No* to part or all of what you asked for, it means they agree with the Level 1 decision. This is called “upholding the decision.” It is also called “turning down your appeal.”

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was a State Fair Hearing, you may ask for a rehearing within 30 days after you receive the decision. You may also ask for judicial review of a State Fair Hearing denial by filing a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after you receive the decision. You cannot ask for an IMR if you already had a State Fair Hearing on the same issue.

If your Level 2 Appeal was an Independent Medical Review, you can request a State Fair Hearing. Go to page 168 for information about asking for a State Fair Hearing.

If your Level 2 Appeal went to the Medicare Independent Review Entity, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 of this chapter for more information on additional levels of appeal.

Section 5.5: Appeal a County’s decision regarding authorized hours for IHSS benefits

In-Home Supportive Services (IHSS) benefits are determined by your county social worker, not our plan. The county social worker will assess the types of services you need and the number of hours the county will authorize for each of these services. If you want to appeal the county’s decision regarding authorized hours for IHSS benefits, you must request a State Fair Hearing.

You must file a request for a State Fair Hearing within 90 days after the date of the county’s action or inaction.

There are two ways to ask for a State Fair Hearing:

1. Fill out the back of the notice of action form and send it to the address indicated, or send a letter to:

   State Hearings Division
   Department of Social Services
   P.O. Box 944243, Mail Station 9-17-37
   Sacramento, California 94244-2430

   OR

2. Call the California Department of Social Services at 1-800-952-5253. TDD users should call 1-800-952-8349.

Section 5.6: Payment problems

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

How do I ask the plan to pay me back for the plan's share of medical services or items I paid for?

You are not responsible for Medicare costs except Part D co-pays. Under some circumstances, you may have cost sharing for Medi-Cal services, such as IHSS and nursing facility stays.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we get your request.

  Or, if you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying *Yes* to your request for a coverage decision.

- If the medical care is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if the plan says they will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity. We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is *Yes* at any stage of the appeals process after Level 2, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says *No* to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 of this chapter for more information on additional levels of appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medi-Cal, you can file a Level 2 Appeal yourself (see Section 5.4 of this chapter). There are two ways to make a Level 2 appeal for Medi-Cal services and items: 1) State Fair Hearing or 2) Independent Medical Review (IMR).

1) State Fair Hearing

You can request a State Fair Hearing at any time for Medi-Cal covered services and items (including IHSS). If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have, you have the right to ask for a State Fair Hearing.

In most cases you have 90 days to ask for a State Fair Hearing after the "Your Hearing Rights" notice is mailed to you. You have a much shorter time to ask for a hearing if your benefits are being changed or taken away.

There are two ways to request a State Fair Hearing:

1. You may complete the "Request for State Fair Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
   - To the county welfare department at the address shown on the notice.
   - To the California Department of Social Services:

     State Hearings Division
     P.O. Box 944243, Mail Station 9-17-37
     Sacramento, California 94244-2430
   - To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.

2. You may make a toll-free call to request a State Fair Hearing at the following number. If you decide to make a request by phone, you should be aware that the phone lines are very busy.
    - Call the California Department of Social Services at 1-800-952-5253. TDD users should call 1-800-952-8349.

2) Independent Medical Review (IMR)

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items (not including IHSS). You must file an appeal with us before requesting an IMR. If you disagree with our decision, you can ask the Help Center for an IMR. You cannot ask for an IMR if you already asked for a State Fair Hearing on the same issue.

An IMR is a review of your case by doctors who are not part of our plan. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You must apply for an IMR within 6 months after we send you a written decision about your appeal.

To request an IMR:

- Fill out the Complaint/Independent Medical Review (IMR) Application Form available at http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_forms.aspx or call the DMHC Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.
- Attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
- Mail or fax your form and any attachments to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: 916-255-5241

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medi-Cal may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs with an ”NT”. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an ”NT” symbol follow the process in **Section 5.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs* (Drug List)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan’s Drug List but we require you to get approval from us before we will cover it for you).
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> ***The legal term*** *for a coverage decision about your Part D drugs is* ***“coverage determination.”***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter. Also see Sections 6.3 and 6.4.	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
    a. If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 2 for brand

name drugs or Tier 1 for generic drugs. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5).

   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - » Quantity limits. For some drugs, the plan limits the amount of the drug you can have.
   - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the co-pay amount we require you to pay for the drug.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say* Yes *or* No *to your request for an exception

- If we say *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say *No* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say *No*.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D Drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 4 to find out how to give permission to someone else to act as your representative.

  ➔ You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”

  Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

***At a glance:* How to ask for a coverage decision about a drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A standard coverage decision means we will give you an answer within 72 hours after we get your doctor’s statement.
- A fast coverage decision means we will give you an answer within 24 hours.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.

    If we decide to give you a standard decision, we will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a “fast complaint” and get a decision within 24 hours.
  - » If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

> ***The legal term*** *for “fast coverage decision” is* ***“expedited coverage determination.”***

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires us to.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an outside independent organization will review your request and our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review the decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review the decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we will make payment to you within 14 calendar days

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

> ***The legal term*** *for an appeal to the plan about a Part D drug coverage decision is plan* ***"redetermination."***

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal.
  - » If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."

- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

> ***The legal term*** *for "fast appeal" is* ***"expedited reconsideration."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said *No* to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review our decision.

➔ **If our answer is *Yes*** to part or all of what you asked for:

  » If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

  » If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say *No* to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Entity other information to support your appeal.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.

- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the Independent Review Entity approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an administrative law judge.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. You can also call 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

  You can also see the notice online at https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

➔ If you need help, please call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The call is free.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date, call Livanta (California's Quality Improvement Organization) at: **1-877-588-1123 (TTY: 1-855-887-6668).**

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization in your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

➔ If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 below.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780 or the Cal MediConnect Ombuds Program at 1-855-501-3077. The number for the ombudsman will be available after April 1, 2014.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal** term for "fast review" is **"immediate review."***

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.

- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> ***The legal term*** *for this written explanation is called the* ***"Detailed Notice of Discharge."*** *You can get a sample by calling Member Services at* ***1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week****. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says *No* and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach Livanta (California's Quality Improvement Organization) at: **1-877-588-1123 (TTY: 1-855-887-6668).**

- \Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

> ***At a glance:* How to make a Level 2 Appeal to change your discharge date**
>
> Call the Quality Improvement Organization in your state and ask for another review.

What happens if the answer is *Yes*?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Review Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Review Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our

> ***At a glance:* How to make a Level 1 Alternate Appeal**
>
> Call our Member Services number and ask for a “fast review” of your hospital discharge date.
>
> We will give you our decision within 72 hours.

decision within 72 hours after you ask for a "fast review."

- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.

  » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

> ***At a glance:* How to make a Level 2 Alternate Appeal**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the Independent Review Entity says *Yes* to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If this organization says *No* to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services (This does not include IHSS. For IHSS problems or complaints, see Section 5.5).
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

  ➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

  ➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your care.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying our share of the cost for your care.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week. Or call your State Health Insurance Assistance Program at 1-213-383-4519, Within L.A. County: (800) 824-0780.

During a Level 1 Appeal, The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

***At a glance:* How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4.

> ***The legal term*** *for the written notice is* ***"Notice of Medicare Non-Coverage."*** *To get a sample copy, call Member Services at* ***1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week*** *or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at http://www.cms.hhs.gov/BNI/*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term*** *for the letter explaining why your services should end is* ***"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say *Yes*?

- If the reviewers say *Yes* to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No*?

- If the reviewers say *No* to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said *No* to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days.

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization in your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says *Yes*?

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No*?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

> ***At a glance:* How to make a Level 1 Alternate Appeal**
>
> Call our Member Services number and ask for a "fast review."
>
> We will give you our decision within 72 hours.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

- **If we say *No*** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.
  - » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

> ***At a glance:* How to make a Level 2 Appeal to require that the plan continue your care**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Organization.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal.
- **If this organization says *Yes*** to your appeal, then we must pay you back for our share of the costs of care. We must also continue the plan's coverage of your services for as long as it is medically necessary.
- **If this organization says *No*** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

> ***The formal name** for "Independent Review Organization" is **"Independent Review Entity."** It is sometimes called the **"IRE."***

Section 9: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Cal MediConnect Ombuds Program at 1-855-501-3077. This number will be available after April 1, 2014.

Section 9.2: Next steps for Medi-Cal services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medi-Cal. If you do not agree with the State Fair Hearing decision and you want another judge to review it, you may request a rehearing and/or seek judicial review.

To request a rehearing, mail a written request (a letter) to:

The Rehearing Unit
744 P Street, MS 19-37
Sacramento, CA 95814

This letter must be sent within 30 days after you receive your decision. In your rehearing request, state the date you received your decision and why a rehearing should be granted. If you want to present additional evidence, describe the additional evidence and explain why it was not introduced before and how it would change the decision. You may contact Legal Services for assistance.

To ask for judicial review, you must file a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after receiving your decision. File your petition in the Superior Court for the county named in your decision. You may file this petition without asking for a rehearing. No filing fees are required. You may be entitled to reasonable attorney's fees and costs if the Court issues a final decision in your favor.

If a rehearing was heard and you do not agree with the decision from the rehearing, you may seek judicial review but you cannot request another rehearing.

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Health Net Cal MediConnect staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

***At a glance:* How to make a complaint**

Call Member Services or send us a letter telling us about your complaint.

➔ If your complaint is about *quality of care*, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> ***The legal term*** *for a "complaint" is a* ***"grievance."***
>
> ***The legal term*** *for "making a complaint" is* ***"filing a grievance."***

Section 10.1: Details and deadlines

- Call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- You must file your complaint with us or the provider within 180 calendar days from the day the incident or action occurred that caused you to be dissatisfied.
- If we cannot resolve your complaint within the next business day, you will receive a letter from us within 5 calendar days of receiving your complaint letting you know that we received it.
- We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information, and the delay is in your

best interest. In certain cases, you have the right to ask for a fast review of your complaint. This is called the “fast complaint” procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:

- We deny your request for a fast review of a request for medical care or Medicare Part D drugs.
- We deny your request for a fast review of an appeal of denied services or Medicare Part D drugs.
- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denied medical care.
- If you have an urgent problem that involves an immediate and serious risk to your health.

- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours. If you have an urgent problem that involves an immediate and serious risk to your health, you can request a “fast complaint” and we will respond within 72 hours.

> ***The legal term*** *for “fast complaint” is* ***“expedited grievance.”***

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

- Most complaints are answered in 30 calendar days. If we need more information and do not come to a decision within 30 days, we will notify you in writing and provide a status update and estimated time for you to get the answer.
- **If we do not agree** with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the Department of Health and Human Services.

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697

You may also have rights under the Americans with Disabilities Act. You can contact the Cal MediConnect Ombuds Program for assistance.

Section 10.3: You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).
- Or you can make your complaint to us *and also* to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is **1-877-588-1123 (TTY: 1-855-887-6668)**.

Section 10.4: You can tell Medicare about your complaint

You can also send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Section 10.5: You can tell Medi-Cal about your complaint

The Cal MediConnect Ombuds Program also helps solve problems from a neutral standpoint to make sure that our members receive all the covered services that we are required to provide. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan.

The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. This number will be available after April 1, 2014. The services are free.

Section 10.6: You can tell the California Department of Managed Health Care about your complaint

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an emergency, you disagree with Health Net Cal MediConnect's decision about your complaint, or Health Net Cal MediConnect has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll free TTY number, 1-877-688-9891. The call is free.

Visit the Department of Managed Health Care's website (http://www.hmohelp.ca.gov).

Chapter 10: Ending your membership in our Cal MediConnect plan

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Introduction

This chapter tells about ways you can end your membership in our Cal MediConnect plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medi-Cal benefits if you leave our plan.

A. When can you end your membership in our Cal MediConnect plan?

You can end your membership in Health Net Cal MediConnect at any time. Your membership will end on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan will end on January 31. Your new coverage will begin the first day of the next month.

When you end your membership in our plan, you will continue to be enrolled in *Health Net Community Solutions, Inc.* for your Medi-Cal services, unless you choose a different Cal MediConnect plan or a different Medi-Cal only plan. You can also choose your Medicare enrollment options when you end your membership in our plan.

→ For information on Medicare options when you leave our Cal MediConnect plan, see the table on page 209.

→ For information about your Medi-Cal services when you leave our Cal MediConnect plan, see page 210.

These are ways you can get more information about how you can end your membership:

- Call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- Call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077.
- Call the California Health Insurance Counseling & Advocacy Program (HICAP) 1-213-383-4519, Within L.A. County: 1-800-824-0780.
- Call the Cal MediConnect Ombuds Program at 1-855-501-3077. This number will be available on April 1, 2014.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

B. How do you end your membership in our Cal MediConnect plan?

If you decide to end your membership, tell Medi-Cal or Medicare that you want to leave Health Net Cal MediConnect:

- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077; OR
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 209.

C. How do you join a different Cal MediConnect plan?

If you want to keep getting your Medicare and Medi-Cal benefits together from a single plan, you can join a different Cal MediConnect plan.

To enroll in a different Cal MediConnect plan:

- Call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077. Tell them you want to leave Health Net Cal MediConnect and join a different Cal MediConnect plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with Health Net Cal MediConnect will end on the last day of the month that we get your request.

D. If you leave our plan and you do not want a different Cal MediConnect plan, how do you get Medicare and Medi-Cal services?

If you do not want to enroll in a different Cal MediConnect plan after you leave Health Net Cal MediConnect, you will go back to getting your Medicare and Medi-Cal services separately.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our Cal MediConnect plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan or Programs of All-inclusive Care for the Elderly (PACE)**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048 to enroll in the new Medicare-only health plan. If you need help or more information: • Call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780. You will automatically be disenrolled from Health Net Cal MediConnect when your new plan's coverage begins.
2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780. You will automatically be disenrolled from Health Net Cal MediConnect when your new plan's coverage begins.

3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780. You will automatically be disenrolled from Health Net Cal MediConnect when your Original Medicare coverage begins.

How you will get Medi-Cal services

If you leave our Cal MediConnect plan, you will continue to get your Medi-Cal services through *Health Net Community Solutions, Inc.* unless you select a different plan for your Medi-Cal services.

Your Medi-Cal services include most long-term services and supports and behavioral health care.

If you want to choose a different plan for your Medi-Cal services, you need to let Health Care Options know when you request to end your membership with our Cal MediConnect plan.

- Call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077. Tell them you want to leave Health Net Cal MediConnect and join a different Medi-Cal plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

When you end your membership with our CalMediConnect plan, you will get a new member ID card, a new *Member Handbook*, and a new *Provider and Pharmacy Directory* for your Medi-Cal coverage.

E. Until your membership ends in our Cal MediConnect plan, you will keep getting your medical services and drugs through our plan

If you leave Health Net Cal MediConnect, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. See page 207 for more information. During this time, you will keep getting your health care and drugs through our plan.

You should use our network pharmacies to get your prescriptions filled. Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.

If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Cal MediConnect plan until you are discharged. This will happen even if your new health coverage begins before you are discharged.

F. Your membership in our Cal MediConnect plan will end in certain situations

These are the cases when Health Net Cal MediConnect must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. *The State of California or Medicare will disenroll you from the Health Net Cal MediConnect Plan and you will return to Original Medicare. If you are receiving Extra Help to pay for your Medicare Part D prescription drugs, CMS will auto-enroll you into a Medicare Prescription Drug Plan.*
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - » If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to prison.

- If you lie about or withhold information about other insurance you have for prescription drugs.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care.
  - » If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. We *cannot* ask you to leave our Cal MediConnect plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, seven days a week.

You should also call the Cal MediConnect Ombuds Program at 1-855-501-3077. This number will be available on April 1, 2014.

H. You have the right to make a complaint if we end your membership in our plan

If we end your membership in our Cal MediConnect plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also see Chapter 9 for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when we can end your membership, you can:

- Call Member Services at 1-855-464-3571 (TTY: 711), 24 hours a day, seven days a week.
- Call Heath Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 5:00 pm. TTY users should call 1-800-430-7077.
- Call the California Health Insurance Counseling & Advocacy Program (HICAP) at 1-213-383-4519, Within L.A. County: 1-800-824-0780.
- Call the Cal MediConnect Ombuds Program at 1-855-501-3077. This number will be available on April 1, 2014.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medi-Cal must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information.

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

The Cal MediConnect program complies with State and Federal laws and regulations relating to the legal liability of third parties for health care services to beneficiaries. We will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

D. Notice of Action

We must use the Notice of Action (NOA) form to notify you of a denial, termination, and delay or modification in benefits. If you disagree with our decision, you can file an appeal with our plan. For Medi-Cal services, you can ask for a State Fair Hearing at the same time. You may have to file an appeal with our plan before you can ask for an Independent Medical Review (IMR), except in some cases. You will not have to pay for any of these proceedings.

E. Recovery of benefits paid by Health Net under your Health Net Cal MediConnect plan

When you are injured

If you are ever injured through the actions of another person, Health Net will provide benefits for all covered services that you receive through this plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the contracted providers retain the right to recover the value of any services provided to you through this plan in accordance with applicable law.

As used throughout this Section E, the term “responsible party” means any party actually or potentially responsible for making any payment to or on behalf of a Member due to a Member’s injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net’s rights of recovery apply to any and all amounts paid to you or on your behalf from the following sources, including but not limited to:

- A third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Any automobile policy, premises or homeowners’ insurance coverage, umbrella coverage;
- Any other source for the responsible parties actions.

By accepting benefits under this plan, you:

- Agree that Health Net has a first priority right of subrogation and reimbursement that applies when this plan has paid benefits for health care expenses you incurred due to the actions of a third party.
- Grant Health Net your right to recover medical expenses from any insurance available up to the full cost of all covered services provided by the plan and you direct such insurance carriers to pay the plan back on your behalf.
- Grant Health Net a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement from a responsible party due to Health Net for the full cost of benefits paid under the plan for your injuries due to a third party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are fully paid for your loss. Health Net may recover the full cost of all benefits provided by this plan without regard to any claim of

fault on the part of the Member, whether by comparative negligence or otherwise. No attorney fees may be deducted from Health Net's recovery, and Health Net is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue the claim or lawsuit against any responsible party.

Nothing in this Section E is intended to reduce or limit the right of DHCS to any recovery from responsible parties, under law or contract, including Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, WIC.

Steps you must take

If you are injured because of a third party, you must cooperate with Health Net's efforts to recover its expenses, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien.
- Promptly responding to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from any responsible party.
- Paying the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due to Health Net for the full cost of benefits paid under the Plan that are for your injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Doing nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and
- Holding any money that you or your lawyer receive from the responsible parties, or from any other source, in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

F. Membership card

A membership card issued by Health Net under this plan is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this plan. To be entitled to services or benefits under this plan, the holder of the card must be eligible for coverage and be a member under this plan. Any person receiving services to which he or she is not then entitled under this plan will be responsible for payment for those services. A Member must present their Health Net membership card, not

their Medicare or Medi-Cal card, when receiving services. Please call Member Services at the number located in Chapter 1 of this Member Handbook if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Health Net is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

G. Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of care.

H. Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan’s toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

I. Circumstances beyond Health Net’s control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events not within the control of Health Net, results in Health Net’s facilities or personnel not being available to provide or arrange for services or benefits under this Member Handbook, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good-faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

J. Notice of Privacy Practices (Rev 09/01/13)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information, and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the notice. We will make any revised Notices available on our website, www.healthnet.com. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals, and others) in your diagnosis and

treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

- **Plan Sponsor.** In addition, we may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you. We can disclose your protected health information to that entity if it has contracted with us to administer your health care program on its behalf.

If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

Person(s) Involved in Your Care or Payment for Your Care.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect, or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.
- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- **Underwriting Purposes.** We may use or disclosure your protected health information for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your protected health information for underwriting purposes, we are prohibited from using or disclosing your protected health information that is genetic information in the underwriting process.

Other Uses or Disclosures that Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing**. We will request your written authorization to use or disclose your protected health information for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.

- **Psychotherapy Notes.** We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures**. All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.
- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment, and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying, and mailing your requested information, but we will tell you the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.
- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision, and we have the right to rebut that statement.
- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate

in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Notice in the Event of a Breach**. You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.
- **Right to a Paper Copy of This Notice**. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative, and technical security measures to safeguard your protected health information.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the U.S. Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. *We will not retaliate against you or penalize you for filing a complaint.*

Contact the Plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Address: Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

Chapter 12: Definitions of important words

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Fair Hearing (see Chapter 9 for more information). This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. As a member of Health Net Cal MediConnect, you only have to pay the plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Cal MediConnect: A program that provides both your Medicare and Medi-Cal benefits together in one health plan. You have one card for all your benefits.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care Plan Optional Services (CPO Services): Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to receive under Medi-Cal.

Care plan: See "Individualized Care Plan."

Care team: See "Interdisciplinary Care Team."

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the $4,550 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible Enrollees who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Co-payment (or Co-pay): A fixed amount you pay as your share of the cost each time you get certain prescription drugs. For example, you might pay $2 or $5 for a prescription drug.

Cost sharing: Amounts you have to pay when you get certain prescription drugs. Cost sharing includes co-payments.

Cost-sharing tier: A group of drugs with the same co-pay. Every drug on the *List of Covered Drugs* is in one of 3 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a co-payment. A daily cost-sharing rate is the co-payment divided by the number of days in a month's supply. Here is an example: If your co-payment for a one-month supply of a drug is $1.20, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $0.04 per day. This means you pay $0.04 for each day's supply when you fill your prescription.

Department of Health Care Services (DHCS): The State department in California that administers the Medicaid Program (referred to as Medi-Cal in California), generally referred to as "the State" in this handbook.

Department of Managed Health Care (DMHC): The State department in California that is responsible for regulating health plans. The DMHC helps people in Cal MediConnect with appeals and complaints about Medi-Cal services. The DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment (DME): Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health Insurance Counseling & Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. Chapter 2 explains how to contact HICAP.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy. This is not your IHSS provider.

Independent Medical Review (IMR): If we deny your request for medical services or treatment, you can file an appeal with us. If you disagree with our decision and your problem is about a Medi-Cal service, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR is decided in your favor, we must give you the service or treatment you requested. You pay no costs for an IMR.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

In-Home Supportive Services (IHSS): A California program that provides personal care services for people who cannot safely remain in their own homes without assistance.

Initial coverage stage: The stage before your total Part D drug expenses reach $4,550. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary.”

Long-term services and supports (LTSS): Long-term services and supports are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing home or hospital. LTSS include In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Nursing Facilities/Sub-Acute Care Facilities (NF/SCF).

Low-income subsidy (LIS): See “Extra Help.”

Medi-Cal: This is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. See Chapter 2 for information about how to contact Medi-Cal.

Medical Group: A group of PCPs, Specialists and other health care Providers that work together. See Chapter 1, Section A for more information.

Medi-Cal Plans: Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or maintain your current health status. The services, supplies, or drugs meet accepted standards of medical practice. Medically Necessary refers to all covered services that are reasonable and necessary to protect life, prevent significant illness or significant Disability, or to alleviate severe pain through the Diagnosis or treatment of disease, illness or injury.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medi-Cal enrollee (Dual Eligible): A person who qualifies for Medicare and Medi-Cal coverage. A Medicare-Medi-Cal enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies

not covered by Medicare Part A or Part B or Medi-Cal. Health Net Cal MediConnect includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medi-Cal may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Model of care: A Model of Care has a lot of different parts. It gives the structure for care management. It guides your healthcare team to get the care for your health needs. A Model of care has healthcare team members. It also has tools to help your team. Some of the tools are surveys. The surveys ask you about your health. Your answers help your team and you make your own care plan that has goals. These goals will help you get to your best health. You and the team also review your progress toward your goals.

Multipurpose Senior Services Program (MSSP): A program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

Network: A team of health care Providers contracted with a Health Plan to provide services. The health care Providers may be contracted directly with the Health Plan or through a Medical Group. See Chapter 1, Section A for more information.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicare and by the state to provide health care services. We call them “network providers” when they agree to

work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman’s services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States and its territores. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. See the definition for “cost sharing” above.

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “Medicare Part D drugs.”

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to

stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3 for information about getting care from primary care providers.

Prior authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Program for All-Inclusive Care for the Elderly (PACE) Plans: A program that covers Medicare and Medi-Cal benefits together for people age 55 and older who need a higher level of care to live at home.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription or how many refills you can get.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4 to learn more about rehabilitation services.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area.

Share of Cost: The portion of your health care costs that you may have to pay each month before Cal MediConnect benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Fair Hearing: If your doctor or other provider asks for a Medi-Cal service that we will not approve, or we will not continue to pay for a Medi-Cal service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you requested.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgent care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.