Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) *Member Handbook*

January 1, 2022 – December 31, 2022

Your Health and Drug Coverage under Health Net Cal MediConnect

Member Handbook Introduction

This handbook tells you about your coverage under Health Net Cal MediConnect through December 31, 2022. 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. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 Plan (Medicare-Medicaid Plan).

ATTENTION: If you speak Arabic, Chinese, Farsi, Spanish, Tagalog or Vietnamese, language assistance services, free of charge, are available to you. Call 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. The call is free.

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- ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-464-3572 (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. The call is free.

- تنبيه: إذا كنت تتحدث العربية، تتوافر لك خدمات المساعدة اللغوية مجانًا. يُرجى الاتصال بالرقم 1-855-464-3572 (TTY: 711)، من الساعة 8:00 صباحًا حتى 8:00 مساءً، من يوم الاثنين إلى الجمعة، وللاتصال في غير أوقات الدوام الرسمي، أيام الأجازات والعطلات ، يمكنك ترك رسالة. سنرد على مكالمتك في يوم العمل التالي. هذه المكالمة مجانية.

- 注意：如果您說中文，可獲得免費的語言協助服務。請致電 *1-855-464-3572（聽語障專線：711），服務時間為週一至週五上午 8 點至下午 8 點。在非工作時間、週末及假日，您可以留言。我們將會在下個工作日回電給您。*此為免費電話。

- توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی، به‌صورت رایگان، دردسترس شما قرار دارد. دوشنبه تا جمعه از ساعت 8 صبح تا 8 شب با شماره 1-855-464-3572 (TTY: 711) تماس بگیرید. پس از این ساعت‌ها، آخر هفته‌ها و تعطیلات رسمی می‌توانید پیام بگذارید. روز کاری بعدی به تماس شما پاسخ داده می‌شود. این تماس رایگان است.

- ATENCIÓN: Si usted habla español, hay servicios de asistencia de idiomas disponibles para usted sin cargo. Llame al 1-855-464-3572 (TTY: 711) de 8:00 a.m. a 8:00 p.m., de lunes a viernes. Después del horario de atención, los fines de semana y los días feriados puede dejar un mensaje. Le devolveremos la llamada el siguiente día hábil. La llamada es gratuita.

- PAALALA: Kung nagsasalita ka ng Tagalog, available sa inyo ang mga serbisyo ng tulog sa wika, nang walang singil. Tumawag sa 1-855-464-3572 (TTY: 711) mula 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Paglipas ng mga oras ng negosyo, tuwing Sabado at Linggo at sa pista opisyal, maaari kang mag-iwan ng mensahe. Ang iyong tawag ay ibabalik sa loob ng susunod na araw ng negosyo. Libre ang tawag.

- XIN LƯU Ý: Nếu quý vị nói tiếng Việt, chú ng tôi sẵn có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi 1-855-464-3572 (TTY: 711) từ 8 giờ sáng đến 8 giờ tối, từ thứ Hai đến hết thứ Sáu. Sau giờ làm việc, vào các ngày cuối tuần và ngày lễ, quý vị có thể để lại tin nhắn. Cuộc gọi của quý vị sẽ được hồi đáp vào ngày làm việc hôm sau. Cuộc gọi này miễn phí.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. The call is free.

Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) wants to make sure you understand your health plan information. We can send materials to you in another language or alternate format if you ask for it this way. This is called a “standing request.” We will document your choice.

Please call us if:

- You want to get your materials in Arabic, Chinese, Farsi, Spanish, Tagalog, Vietnamese or in an alternate format. You can ask for one of these languages in an alternate format.
- You want to change the language or format that we send you materials.

If you need help understanding your plan materials, please contact Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711). Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

2022 Health Net Cal MediConnect *Member Handbook*

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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.
- Out-of-network/non-contracted providers are under no obligation to treat Health Net Cal MediConnect members, except in emergency situations. Please call our Member Services number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.
- Coverage under Health Net Cal MediConnect is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Health Net Cal MediConnect, a health plan that covers all your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you will get from Health Net Cal MediConnect. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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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 the State of 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 get your Medicare and Medi-Cal services.

Experience you can count on

You've enrolled in a health plan 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 pride ourselves on providing excellent customer service; this is accomplished by providing focused, positive, personalized attention to you as our member. Our trained Member Services staff will not keep you waiting and can support multiple languages through the use of interpreter services. We will provide you with a "concierge" level of service in helping you navigate through your benefits as we would our own family, this will quickly get the answers you need to access care.
- We've been building high-quality networks of doctors for nearly 25 years. The doctors and specialists in our Cal MediConnect network work together in Medical Groups to make sure you get the care you need, when you need it.
- 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. Information about Medicare and Medi-Cal

B1. 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).

B2. 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 (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

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 the State of 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 will not be affected.

C. 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 be able to work with **one** health plan for **all** of your health insurance needs.
- 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. Health Net Cal MediConnect's service area

Our service area includes this county in California: San Diego.

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. Refer to Chapter 8, Section J, page 189 for more information about the effects of moving out of our service area. You will need to contact your local county eligibility worker:

CALL	1-866-262-9881 This call is free. Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
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	Mail applications or verifications to: County of San Diego Health and Human Services Agency APPLICATION PO Box 85025 San Diego, CA 92186-9918
WEBSITE	www.sandiegocounty.gov/content/sdc/hhsa/programs/ssp/medi-cal_program.html

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 who meet the share of cost provisions described below:
  - Nursing facility residents with a share of cost, **and**
- Are a United States citizen or are lawfully present in the United States.

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 get a health risk assessment (HRA) within the first 45 and 90 days depending on your health status (i.e. high or low risk).

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, 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 using the doctors you use now for a certain amount of time. You can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

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

- We can establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say existing relationship, it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in Health Net Cal MediConnect.
    - We will determine an existing relationship by reviewing your health information available to us or information you give us.
    - 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.
    - We have 3 calendar days to respond to your request if there is a risk you will be harmed due to an interruption in your care.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: 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 use doctors and other providers in the Health Net Cal MediConnect network that are affiliated with your primary care provider's medical group, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. When you enroll in our plan, you will choose a contracting Medical Group from our network. A *medical group* is a group of PCPs, specialists, and other health care providers that work together and are contracted to work with our plan. You will also choose a primary care provider (PCP) from this contracting Medical Group. If you do not choose a Medical Group and contracting PCP, we will assign one to you. Refer to Chapter 3, Section D, page 46 for more information on getting care.

G. Your Care Team and Care Plan

G1. Care Team

Do you need help getting the care you need? A care team can help you. A care team may include your doctor, a care coordinator, or other health person that you choose.

A care coordinator is a person who is trained to help you manage the care you need. You will get a care coordinator when you enroll in Health Net Cal MediConnect. This person will also refer you to community resources, if Health Net Cal MediConnect does not provide the services that you need.

You can call us at 1-855-464-3572 (TTY: 711) to ask for a care team. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

G2. Care Plan

Your care team will work with you to come up with a care plan. A care plan tells you and your doctors what services you need, and how you will get them. It includes your medical, behavioral health, and LTSS needs. Your care plan will be made just for you and your needs.

Your care plan will include:

- Your health care goals.
- A timeline for when you should get the services you need.

After your health risk assessment, your care team will meet with you. They will talk to you about services you need. They can also tell you about services you may want to think about getting. Your care plan will be based on your needs. Your care team will work with you to update your care plan at least every year.

H. Health Net Cal MediConnect monthly plan premium

Health Net Cal MediConnect does not have a monthly plan premium.

I. 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, refer to Chapter 9, Section D, page 197, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You can also refer to the *Member Handbook* at mmp.healthnetcalifornia.com or download it from this website.

The contract is in effect for the months you are enrolled in Health Net Cal MediConnect between January 1, 2022 and December 31, 2022.

J. Other information you will get from us

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

J1. 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 is 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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. If you show your Medicare card instead of your Health Net Cal MediConnect Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7, Section A, page 153 to find out what to do if you get a bill from a provider.

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

J2. *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 (refer to page 12).

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You can also refer to the *Provider and Pharmacy Directory* at mmp.healthnetcalifornia.com 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 and pharmacies. This *Provider and Pharmacy Directory* lists health care professionals (such as doctors, nurse practitioners and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Health and Home Health providers) that you may see as a Health Net Cal MediConnect member. We also list the pharmacies that you may use to get your prescription drugs. Pharmacies listed in the *Provider and Pharmacy Directory* include Retail, Mail Order, Home Infusion, Long-Term Care (LTC), Indian Tribal Health Service/Tribal/Urban Indian Health Program (I/T/U) and Specialty.

Definition of network providers

- Health Net Cal MediConnect's network providers include:
    - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - LTSS, behavioral health services, home health agencies, durable 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.

Definition of 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 1-855-464-3572 (TTY: 711) for more information. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Both Member Services and Health Net Cal MediConnect's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells you 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. Refer to Chapter 5, Section C, page 130 for more information on these rules and restrictions.

Each year, we will send you information about how to access 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 mmp.healthnetcalifornia.com or call 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. Chapter 6, Section A, page 143 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

K. How to 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:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.
- Admission to a nursing home or hospital.
- Care in a hospital or emergency room.
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study.

If any information changes, please let us know by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). State and federal laws require that we keep your PHI private. We make sure that your PHI is protected. For more details about how we protect your PHI, refer to Chapter 8, Section C1, page 171.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Health Net Cal MediConnect and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. How to contact Health Net Cal MediConnect Member Services

CALL	1-855-464-3572 This call is free. Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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. Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
FAX	1-800-281-2999 or 1-866-461-6876
WRITE	Health Net Community Solutions, Inc. PO Box 10422 Van Nuys, CA 91410-0422
WEBSITE	mmp.healthnetcalifornia.com

A1. When to contact Member Services

- Questions about the plan
- Questions about claims, billing or Member ID 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, refer to Chapter 9, Section D, page 197.

- 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, refer to Chapter 9, Section D, page 197.
- 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 (refer to Section F below, page 31).
  - You can call us and explain your complaint. Call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above, page 22).
  - You can send a complaint about Health Net Cal MediConnect to Medicare. You can use an online form at 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 (TTY: 711).
  - To learn more about making a complaint about your health care, refer to Chapter 9, Section J, page 242.
- 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, refer to Chapter 9, Section F4, page 220.

- 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 Part D prescription drugs over the phone, please contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You may also fax your request to 1-866-388-1766. If you would like to make your appeal or compliant in writing, please send your appeal to the address below.

    Health Net Community Solutions, Inc.
    Medicare Part D Appeals
    PO Box 31383
    Tampa, FL 33631-3383

  - For more information on how to make an appeal about your Medi-Cal drugs over the phone, please contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You may also fax your request to 1-877-713-6189. If you would like to make your appeal or compliant in writing, please send your appeal to the address below.

    Health Net Community Solutions, Inc.
    Attn: Appeals & Grievances Dept.
    PO Box 10422
    Van Nuys, CA 91410-0422

  - For more on making an appeal about your prescription drugs, refer to Chapter 9, Section F5, page 223.

- 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. (Refer to the section above, page 23.)
    - You can send a complaint about Health Net Cal MediConnect to Medicare. You can use an online form at 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, refer to Chapter 9, Section J, page 242.
- 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 got, refer to Chapter 7, Section A, page 153.
    - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9, Section D, page 197 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. Your care coordinator will contact you when you enroll in our plan.

Member Services can also let you know how you can contact your care coordinator. A care coordinator helps put together health care services to meet your health care 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 health care. This will also help you make choices that are right for you. You can call Member Services if you need help getting in contact with your care coordinator.

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

You can also call your care coordinator before they contact you. Call the number below and ask to speak to your care coordinator.

CALL	1-855-464-3572 This call is free. Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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. Monday through Friday, 8:00 a.m. to 8:00 p.m. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
WRITE	Health Net Community Solutions, Inc. PO Box 10422 Van Nuys, CA 91410-0422

B1. When to contact your care coordinator

- 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 Community-Based Adult Services (CBAS) 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:

- Community-Based Adult Services (CBAS),
- Skilled nursing care,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services, **and**
- Home health 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)

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

The Health Net Cal MediConnect Nurse Advice Call Line is a service that offers toll-free telephonic coaching and nurse advice from trained clinicians that are available 24 hours a day, 7 days a week, 365 days a year. The Nurse Advice Call Line provides real time health care assessments to help the member determine the level of care needed at the moment. Clinicians provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the Nurse Advice Call Line by calling the Health Net Cal MediConnect Member Services number on the back of their Member ID Card.

CALL	1-855-464-3572 This call is free. Coaching and nurse advice from trained clinicians are available 24 hours a day, 7 days a week, 365 days a year. 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. Coaching and nurse advice from trained clinicians are available 24 hours a day, 7 days a week, 365 days a year.

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

D. How to contact the Behavioral Health Crisis Line

Managed Health Network (MHN) operates a 24/7 behavioral health crisis line for members requiring this type of assistance. At any point during the call members can ask to speak to a licensed clinician, who can assist them in obtaining the services that they require. Members can access this crisis line by calling the number below.

CALL	1-855-464-3572 This call is free. Licensed Behavioral Health clinicians are available 24 hours a day, 7 days a week, 365 days a year. 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. Licensed Behavioral Health clinicians are available 24 hours a day, 7 days a week, 365 days a year.

D1. When to contact the Behavioral Health Crisis Line

- 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, 365 days a year for behavioral health clinical questions.

For questions regarding your county specialty mental health services, refer to page 36.

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	1-800-434-0222 Within San Diego County: 1-858-565-8772 Monday through Friday, 9:00 a.m. to 8:00 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. Monday through Friday, 9:00 a.m. to 8:00 p.m.
WRITE	HICAP (Elder Law & Advocacy) 5151 Murphy Canyon Road, Suite 110 San Diego, CA 92123
WEBSITE	http://seniorlaw-sd.org/programs/health-insurance-counseling-advocacy-program-hicap/

E1. When to contact HICAP

- Questions about your Cal MediConnect plan or other Medicare questions
    - HICAP counselors can answer your questions about changing to a new plan and help you:
        - understand your rights,
        - understand your plan choices,
        - make complaints about your health care or treatment, **and**
        - straighten out problems with your bills.

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

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

CALL	1-877-588-1123
TTY	1-855-887-6668 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

F1. When to contact Livanta

- Questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - 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	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, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what 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.

CALL	1-844-580-7272 Health Care Options representatives are available between the hours of 8:00 a.m. and 6:00 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	www.healthcareoptions.dhcs.ca.gov

I. How to contact the Cal MediConnect Ombuds Program

The Cal MediConnect Ombuds Program works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Cal MediConnect Ombuds Program can also help you with service or billing problems. The Cal MediConnect Ombuds Program is not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-855-501-3077 This call is free. Monday through Friday, 9:00 a.m. to 5:00 p.m., except holidays.
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. Monday through Friday, 9:00 a.m. to 5:00 p.m., except holidays.
WRITE	Legal Aid Society of San Diego Consumer Center for Health Education & Advocacy 1764 San Diego Avenue, Suite 100 San Diego, CA 92110
WEBSITE	https://www.lassd.org/area/health

J. How to contact County Social Services

If you need help with your services for which County Social Services provides assistance, such as applicable benefits, contact your local County Social Services Department.

CALL	1-800-339-4661 This call is free. Monday, Tuesday, Wednesday and Friday, 8:00 a.m. to 5:00 p.m. On Thursday, 10:00 a.m. to 5:00 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. Monday, Tuesday, Wednesday and Friday, 8:00 a.m. to 5:00 p.m. On Thursday, 10:00 a.m. to 5:00 p.m.
WRITE	Refer to the White Pages under COUNTY GOVERNMENT of your phone book for the nearest social services office.
WEBSITE	https://www.sandiegocounty.gov/hhsa/programs/

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	County of San Diego Behavioral Health Services: 1-888-724-7240 This call is free. 24 hours a day, 7 days a week, 365 days a year 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, 7 days a week, 365 days a year

K1. Contact the county specialty mental health plan about:

- Questions about behavioral health services provide by the county
- For free, confidential mental health information, referrals to service providers, and crisis counseling at any day or time, call the County of San Diego Behavioral Health Services 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.
TDD	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	www.dmhc.ca.gov

M. Other resources

Aging & Independence Services

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

CALL	1-800-339-4661 Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
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. Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
WRITE	San Diego County Aging & Independence Services (AIS) 5560 Overland Ave, Suite 310 San Diego, CA 92123
WEBSITE	http://www.sdcounty.ca.gov/hhsa/programs/ais/

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	1-866-262-9881 This call is free Monday through Friday, 7:00 a.m. to 5:00 p.m., except holidays
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. Monday through Friday, 7:00 a.m. to 5:00 p.m., except holidays
WRITE	Health & Human Services Agency Access Benefits P.O. Box 939043 San Diego, CA 92193
WEBSITE	www.accessbenefitssd.com

Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are age 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 This call is free. Monday through Friday, 8:00 a.m. to 7:00 p.m. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week, 365 days a year.
TTY	1-800-325-0778 This call is free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Monday through Friday, 8:00 a.m. to 7:00 p.m. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week, 365 days a year.
WEBSITE	www.ssa.gov

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Health Net Cal MediConnect. It also tells you about your care coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information 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 (LTSS) are listed in the Benefits Chart in Chapter 4, Section D, page 70.

Providers are doctors, nurses, and other people who give you services and care. The term providers also include 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 (LTSS).

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 use a network provider, you usually pay nothing for covered services.

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

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

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

- 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, Section D, page 70 of this handbook).
- The care must be determined **medically necessary.** By medically 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 use 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 someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Health Net Cal MediConnect may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. To learn more about referrals, refer to page 46.
    - Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP will be referring you to specialists and services that are also affiliated with their medical group. A medical group is group of PCPs, specialists, and other health care providers that work together and are contracted to work with our plan.
    - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 48.
    - To learn more about choosing a PCP, refer to page 47.
- **You must get your care from network providers that are affiliated with your PCP's medical group**. Usually, the plan will not cover care from a provider who does not work with the health plan and your PCP's medical group. 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 find out what emergency or urgently needed care is, refer to Section H, page 57.
    - 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 an out-of-network provider, prior authorization will be required. Once prior authorization is approved, the requesting provider and the accepting provider will be notified of the approval. In this situation, we will cover the care at no cost to you. To learn about getting approval for an out-of-network provider, refer to Section D, page 46.
    - 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 ask to continue to use your current providers. With some exceptions, we are required to approve this request if we can establish that you had an existing relationship with the providers (refer to Chapter 1, page 12). If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network that are affiliated with your PCP's medical group. After 12 months, we will no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's medical group.

C. Information about your care coordinator

C1. What a care coordinator is

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 helps put together health care services to meet your health care 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 health care. This will also help you make choices that are right for you.

C2. How you can contact your care coordinator

A care coordinator will be assigned to you when you become a plan member. Your care coordinator will contact you when you enroll in our plan. Member Services can also let you know how you can contact your care coordinator. You can call Member Services if you need help getting in contact with your care coordinator.

C3. How you can change your care coordinator

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

If you need more help, please call our Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.

Definition of a "PCP," and what a PCP does 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 doctor who meets state requirements and is trained to give you basic medical care. These include doctors providing general and/or family medical care, internal medical care, and Obstetrician-gynecologist (OB/GYNs) who provide care for women.

You will get most of your routine or basic care from your PCP. Your PCP will help you manage 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 prior 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 non-physician medical practitioner as your PCP. Non-physician practitioners include: certified nurse midwives, certified nurse practitioners, and physicians assistants. You will be linked to the supervising PCP, but you will continue to receive services from your chosen non-physician practitioner. You are allowed to change your choice of practitioner by changing the supervising PCP. Your ID card will be printed with the name of the supervising PCP. You may be able to have a specialist act as your PCP. Specialists must be willing and able to provide the care you need.

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*.

Your choice of PCP

When you enroll in our plan, you will choose a contracting Medical Group from our network. A medical group is a group of PCPs, specialists, and other health care providers that work together and are contracted to work with our plan. You will also choose a PCP from this contracting Medical Group. Your primary care doctor's office should be easy for you to get to. You can ask for a PCP within 10 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 website at mmp.healthnetcalifornia.com. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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 Member ID 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 "Option to change your PCP" below.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our plan network, we can help you find a new PCP who is within our plan network if the one you now have leaves our 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 at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day or visit our website at mmp.healthnetcalifornia.com 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 Member ID card that shows the name and phone number of your new PCP.

Remember, our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for the change, be sure to tell Member Services whether you are using a specialist or getting other covered services that require PCP approval. Member Services will help make sure that you can continue your specialty care and other services when you change your PCP.

Services you can get without first getting approval from your PCP

In most cases, you will need approval from your PCP before using 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 COVID-19 vaccinations as well as hepatitis B vaccinations 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 get services from Indian health providers, you may use these providers without a referral.
- Family planning services from network providers and out-of-network providers.
- Basic prenatal care, sexually transmitted disease services and HIV testing.

See Chapter 4 for details on which covered services may require an approval in advance, such as a referral or prior authorization from your PCP.

D2. 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 "Option to change 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 prior 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.

D3. What to do when a provider leaves our plan

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. For assistance, please contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

D4. How to get care from out-of-network providers

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, family planning services 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.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medi-Cal.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medi-Cal.
- If you use 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.

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

Long-term services and supports (LTSS) consist of Community Based Adult Services (CBAS) 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, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services if you meet applicable eligibility criteria.
- **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 your care coordinator at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

F. How to get behavioral health (mental health and 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 the County of San Diego Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS).

F1. What Medi-Cal behavioral health services are provided outside of Health Net Cal MediConnect through *the* County of San Diego Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS)

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 the County of San Diego Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS) 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 the County of San Diego Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS) if you meet the Drug Medi-Cal medical necessity criteria. Drug Medi-Cal services provided by the County of San Diego

Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS) 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 at a Medicare Certified facility.
- 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day or visit our website at mmp.healthnetcalifornia.com.

Behavioral Health services exclusions and limitations

For a list of Behavioral Health services exclusions and limitations, please see Chapter 4, Section F, page 115: Benefits not covered by Health Net Cal MediConnect, Medicare, or Medi-Cal.

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 prior authorization for these services, you must call Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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 Cal MediConnect 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 the County of San Diego Behavioral Health Services (BHS): Mental Health Plan (MHP) and Alcohol & Drug Services (ADS)

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 Cal MediConnect by calling the number that appears on your Member ID Card. Health Net Cal MediConnect will confirm eligibility and authorize the services when appropriate.

Health Net Cal MediConnect will work with San Diego 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. Refer to Chapter 9, Section J, page 242 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 in the 12 months prior to enrollment. 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

G. How to get transportation services

Health Net Cal MediConnect is partnering with ModivCare Solutions, LLC (previously called LogistiCare) to provide Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services to members enrolled in our plan.

Non-Emergency Medical Transportation (NEMT)

Non-emergency medical transportation necessary to obtain covered medical services and subject to the written prescription of a physician, dentist or podiatrist and only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private transportation.

The NEMT transportation benefit consists of:

- Unlimited round trips per member per calendar year with no charge
- Ambulance, wheelchair vans and litter vans
- Service to and from medical appointments 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

Non-Medical Transportation (NMT)

NMT includes transportation to medical services by passenger car, taxi, or other forms of public/private transportation provided by persons not registered as Medi-Cal providers. This service includes mileage reimbursement to drivers as long as they are not the member. If you want to be driven by a friend or family member and want to receive reimbursement, please call MotivCare.

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

The NMT transportation benefit consists of:

- Unlimited round trips per member per calendar year with no charge
- Curb-to-curb service
- Taxi, standard passenger vehicle, mini-van and other modes of public/private transportation
- Mileage reimbursement to drivers as long as they are not the member
- Service to and from medical appointments 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

To request transportation services described above, contact Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

The transportation request must be submitted seven calendar days in advance for both non-emergency medical transportation and non-medical transportation.

If you need to arrange services with shorter notice, these requests will be considered on a case-by-case basis and will depend on the nature of the appointment, when the appointment for the medical service was arranged and availability of transportation resources.

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

H1. Care when you have a medical emergency

Definition of 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 does not get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- Serious risk to your health or to that of your unborn child; **or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to 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 you tell our plan 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. However, you will not have to pay for emergency services because of a delay in telling us. Contact Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a secure message. Your call will be returned within the next business day.

Covered services in 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, refer to the Benefits Chart in Chapter 4, Section D, page 70.

Coverage is limited to the United States and its territories (U.S.): 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.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You might go in for emergency care and have the doctor say it wasn't really an 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. (Refer to the next section.)

H2. Urgently needed care

Definition of 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.

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, 7 days a week, 365 days a year 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, our Nurse Advice Call Line is available to you any time, day or night. You can reach our Nurse Advice Call Line by calling 1-855-464-3572 (TTY: 711). As a Health Net Cal MediConnect member, you have access to triage or screening services, 24 hours a day, 7 days a week, 365 days a year. You can also contact Member Services at 1-855-464-3572 (TTY: 711) if you need help locating a provider. Member Services can also transfer you to the Nurse Advice Call Line. Member Services is available from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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

When you are outside the plan's 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 non-emergency care that you get outside the United States.

H3. Care during a disaster

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

Please visit our website for information on how to obtain needed care during a declared disaster: mmp.healthnetcalifornia.com.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

I. What to do if you are billed directly for 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 gotten a bill for the full cost of covered medical services, refer to Chapter 7, Section A, page 153 to learn what to do.

I1. What to do if services are not covered by our plan

Health Net Cal MediConnect covers all services:

- That are determined medically necessary, **and**
- That are listed in the plan's Benefits Chart (refer to Chapter 4, Section D, page 70), **and**
- That you get by following plan rules.

If you get services that are not 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. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section D, page 197 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. Coverage of health care services when you are in a clinical research study

J1. Definition of 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.

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 find out 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.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan 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.

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

J2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. 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.

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

J3. Learning more about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.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 your health care services are covered when you get care in a religious non-medical health care institution

K1. Definition of 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.

K2. Getting care from a religious non-medical health care institution

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.

- 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.

There is unlimited coverage for inpatient hospital care as long as you meet the requirements above.

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME means certain items ordered by a provider for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Health Net Cal MediConnect, you may acquire ownership of DME 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 Cal MediConnect. Call Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), to find out about the rental or ownership requirements of durable medical equipment and the documentation you need to provide. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

In certain situations, we will transfer ownership of the DME item to you. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

If you acquire ownership of a durable medical equipment item while you are a member of our plan, and the equipment requires maintenance, then the provider is allowed to bill the cost of the repair.

L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2022* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- You did not become the owner of the DME 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 or a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage payments do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned to the owner when it's no longer medically necessary for you or if you leave our plan.

L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Health Net Cal MediConnect covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

This chapter tells you what services Health Net Cal MediConnect pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section A, page 124. 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. Refer to Chapter 3, Section B, page 43 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

A1. During public health emergencies

Health Net Cal MediConnect will follow any and all state and/or federal guidance related to a public health emergency (PHE). During a PHE, the plan will provide all necessary coverage for our members. The coverage may vary depending on the services received and the duration of the PHE. Please visit our website for more information on how to obtain needed care during a PHE at mmp.healthnetcalifornia.com or call Member Services. You can reach Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

B. Rules against providers charging you for services

We do not allow Health Net Cal MediConnect providers to bill you for covered 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 for covered services. If you do, refer to Chapter 7, Section A, page 153 or call Member Services.

C. Our plan's Benefits Chart

The 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 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. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
- 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, Section D, page 46 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 use someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3, Section D, page 46 has more information about getting a referral and explains when you do not need a referral.
- You must get care from providers that are affiliated with your PCP's medical group. Refer to Chapter 3, Section D, page 46 for more information.
- 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 prior authorization first are marked in the Benefits Chart in italic type.
- All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.

- Care Plan Optional (CPO) services may be available under your Individualized Care Plan. These services give you more help at home, like meals, help for you or your caregiver, or shower grab bars and ramps. These services can help you live more independently but do **not** replace long-term services and supports (LTSS) that you are authorized to get under Medi-Cal. Examples of CPO services that Health Net Cal MediConnect has offered in the past include: Respite care for family caregivers up to 24 hours every 6 months and Special Services for Groups (SSG) where home visits are scheduled and conducted with the goal of connecting our members to community resources. If you need help or would like to find out how CPO services may help you, contact your care coordinator.

D. The Benefits Chart

Services that our plan pays for	
🍎	**Abdominal aortic aneurysm screening** We will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. *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.*
	Acupuncture We will pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary. We will also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. In addition, we will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.

Services that our plan pays for	
	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 ground, fixed-wing, and rotary-wing 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 health or life. 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.*
	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. *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	
	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 *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.*
	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. *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	
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the visit, your doctor may: • Discuss aspirin use, • Check your blood pressure, **and/or** • Give you tips to make sure you are eating well. *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.*
	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 or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years *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	
	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.* *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 • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years • Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) • Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 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.*
	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 separately. *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	
	Counseling to stop smoking or tobacco use If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We will pay for two quit attempts in a 12 month period as a preventive service. This service is free for you. Each quit attempt includes up to four counseling face-to-face visits. 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. If you are pregnant, you may get unlimited tobacco cessation counseling with prior authorization. *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.*
	Dental services Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. Refer to Section E2 for more information about this benefit. *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.*
	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.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

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), including the fitting, and two extra pairs of inserts each calendar year, **or**
  - One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
- We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Member Services.

Diabetic glucometer and supplies are limited to Accu-Chek and OneTouch when obtained at a Pharmacy. Other brands are not covered unless pre-authorized.

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 (DME) and related supplies (For a definition of "Durable medical equipment (DME)," refer to Chapter 12, page 265 of this handbook.) The following items are covered: • Wheelchairs • Crutches • Powered mattress systems • Dry pressure pad for mattress • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Enteral pump and supplies • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment Other items may be covered. We will pay for all medically necessary DME 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. **This benefit is continued on the next page**

Services that our plan pays for	
	Durable medical equipment (DME) and related supplies (continued) Please contact member services to assist you in locating another supplier that may carry the specific item. Non-Medicare covered Durable Medical Equipment for use outside the home is also covered. *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*

	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 does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• Serious risk to your health or to that of your unborn child; **or**
	• Serious harm to bodily functions; **or**
	• Serious dysfunction of any bodily organ or part; **or**
	• In the case of a pregnant woman in active labor, when:
	  ○ There is not enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	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 (U.S.): 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, page 57 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 (IUC/IUD, implants, injections, birth control pills, patch, or ring)
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)
- Counseling and diagnosis of infertility and related services
- Counseling, testing, and treatment for sexually transmitted infections (STIs)
- Counseling and testing for HIV and AIDS, and other HIV-related conditions
- Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)
- Genetic counseling

We will also pay for some other family planning services. However, you must refer to 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

Services that our plan pays for	
	**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** • Nursing Hotline • Fitness Benefit The fitness benefit provides a basic fitness membership at participating facilities, or you may request an in-home fitness program that includes a wearable fitness tracker. *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	
	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. If you are pregnant or reside in a nursing facility, 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 (a fiscal year runs from July through June of the following year). If you are pregnant the $1,510 maximum benefit amount does not apply to you. Replacement of hearing aids that are lost, stolen or destroyed due to circumstances 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. We will also pay for additional HIV screening(s) when recommended by your provider. *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	
	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: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies *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 infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. *Prior authorization (approval in advance) may be required to be covered, except in an emergency*

Services that our plan pays for	
	Hospice care You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **This benefit is continued on the next page**

Services that our plan pays for	
	Hospice care (continued) **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to Section F of this chapter for more information. **For services covered by Health Net Cal MediConnect but not covered by Medicare Part A or B:** • Health Net Cal MediConnect 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 prognosis. You pay nothing for these services. **For drugs that may be covered by Health Net Cal MediConnect's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3, page 136. **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 prognosis. You can call your care coordinator at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit *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	
	Immunizations We will pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • 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, Section H, page 150 to learn more. We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP). *You should talk to your provider and get a referral for Hepatitis B or other vaccines.* *Prior authorization (approval in advance) is not required for the Pneumonia vaccine or flu shots.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency, for Hepatitis B or other vaccines.*
	Inpatient hospital care We will pay for the following services and other medically necessary 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 **This benefit is continued on the next page**

Services that our plan pays for	
	Inpatient hospital care (continued) • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, 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. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Health Net Cal MediConnect provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. • Blood, including storage and administration • Physician services You must get approval from the plan to keep getting inpatient care at an out-of-network after your emergency is stabilized. *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	
	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. ○ 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 you got 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 stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay
	
	If your inpatient stay is not reasonable and medically necessary, we will not pay for it.
	
	However, in certain situations where inpatient care is not covered, we may still pay for services you get while you are in a hospital or nursing facility. To find out more, contact Member Services.
	
	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

Services that our plan pays for	
	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, Section D4, page 51 • 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. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart. *You should talk to your provider and get a referral.*
🍎	**Lung cancer screening** The plan will pay for lung cancer screening every 12 months if you: • Are aged 50-80, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider. *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	
	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 get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We may approve additional services if medically necessary. We will 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. We may approve additional services if medically necessary. *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 Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle. *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	
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Some drugs may be subject to step therapy. Health Net Cal MediConnect 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 **This benefit is continued on the next page**

Services that our plan pays for	
	Medicare Part B prescription drugs (continued) • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B drugs that may be subject to step therapy: https://mmp.healthnetcalifornia.com/mmp/resources.html We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. Chapter 5, Section A, page 124 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6, Section D3, page 147 explains what you pay for your outpatient prescription drugs through our plan. *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 (NEMT) 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 para transit. 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. To request transportation services described above, contact Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. The transportation request must be submitted seven calendar days in advance for both non-emergency medical transportation and non-medical transportation. If you need to arrange services with shorter notice, these requests will be considered on a case-by-case basis and will depend on the nature of the appointment, when the appointment for the medical service was arranged and availability of transportation resources. ModivCare (previously called LogistiCare) will facilitate getting a prescription (Physician Certification Statement form) from your provider. *You should talk to your provider and get a referral.* *Depending on the service, prior authorization (approval in advance) may be required.*

Services that our plan pays for	
	Non-medical transportation (NMT) This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. This benefit does not limit your non-emergency medical transportation benefit. Please refer to Chapter 3, Section G, page 55 for additional information on Transportation services. To request transportation services described above, contact Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. The transportation request must be submitted seven calendar days in advance for both non-emergency medical transportation and non-medical transportation. If you need to arrange services with shorter notice, these requests will be considered on a case-by-case basis and will depend on the nature of the appointment, when the appointment for the medical service was arranged and availability of transportation resources. ModivCare (previously called LogistiCare) will facilitate getting a prescription (Physician Certification Statement form) from your provider. *You should talk to your provider and get a referral.*

Services that our plan pays for

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 necessary)
- Meals, including special diets
- Nursing services
- Physical therapy, occupational therapy, and speech therapy
- Respiratory 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
- 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
- Vision benefits

This benefit is continued on the next page

Services that our plan pays for	
	Nursing facility care (continued) • Hearing exams • 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 or domestic partner is living at the time you leave the hospital. *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.*
	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.* *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

Services that our plan pays for	
	Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) *Prior authorization (approval in advance) may be required to be covered, except in an emergency.*
	Outpatient diagnostic tests and therapeutic services and supplies We will pay for the following services and other medically necessary 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 (includes complex tests such as CT, MRI, MRA, SPECT) *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	

	Outpatient hospital services
	
	We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:
	• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.”
	  ○ Sometimes you can be in the hospital overnight and still be an “outpatient.”
	  ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf
	• 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
	• Preventive screenings and services listed throughout the Benefits Chart
	• Some drugs that you can’t give yourself
	
	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	
	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.*

Services that our plan pays for	
	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 your provider and get a referral.* *Prior authorization (approval in advance) may be required to be covered, except in an 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 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	
	Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service 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. **Note:** Because a Medicare certification is required for Cal MediConnect, 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.*

	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, if your doctor orders them to find out whether you need treatment
	
	This benefit is continued on the next page

Services that our plan pays for	
	Physician/provider services, including doctor's office visits (continued) 1. Certain telehealth services, including those for: primary care, specialist and other health care professional services, and outpatient mental health specialty services, including psychiatric care. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. 2. Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home 3. Telehealth services to diagnose, evaluate, or treat symptoms of a stroke 4. Telehealth services for members with a substance use disorder or co-occurring mental health disorder o Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if you're not a new patient. o Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if you're not a new patient. 5. Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: o Surgery of the jaw or related structures o Setting fractures of the jaw or facial bones o Pulling teeth before radiation treatments of neoplastic cancer o Services that would be covered when provided by a physician *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	
	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 *You should talk to your provider and get a referral.*
	Prostate cancer screening exams For men age 50 and older, we will pay for the following services once every 12 months: • 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 • Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Prostheses to replace all of part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect • 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. Refer to “Vision Care” later in this section, page 109 for details. We will not pay for prosthetic dental devices. *You should talk to your provider and get a referral for incontinence supplies and diapers.* *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. *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	
	**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. 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*

Services that our plan pays for	
	Skilled nursing facility (SNF) 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 necessary • 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 or domestic partner lives at the time you leave the hospital *Prior authorization (approval in advance) may be required to be covered, except in an emergency*

Services that our plan pays for	
	Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques *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*
	Urgent care Urgent care is care given to treat: • A non-emergency that requires immediate medical care, **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.

Services that our plan pays for	
	Vision care We will pay for the following services: • One routine eye exam every year; **and** • Up to $100 for eyeglasses (standard and non-standard frames and basic single vision, bifocal, trifocal or lenticular eyeglass lenses) every two years. • Up to $100 for elective contact lenses, fitting and evaluation every two years*, **, ***. • Low vision exam (up to four times per year)**** • Low vision aid**** **From the date of service*/purchase, multi-year benefits may not be available in subsequent years. **You are responsible for 100% of any remaining balance over the $100 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. **This benefit is continued on the next page**

Services that our plan pays for	
	Vision care (continued) Low vision aid including: • 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 Vision care (continued)Medical Eye Services: You should talk to your provider and get a referral for Medicare-covered vision exams. 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. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and 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. **This benefit is continued on the next page**

Services that our plan pays for	
	Vision care (continued) **How to use your vision benefits** This plan provides coverage for a routine eye exam annually and eyewear every 24 months. You will obtain your annual routine vision examination (to determine the need for corrective eyewear) and any applicable eyewear through a participating vision provider, not your medical group. Make arrangements for your annual routine vision examination with a participating vision provider. To locate a participating vision provider, call Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Or you can look one up online at mmp.healthnetcalifornia.com. You are able to purchase eyewear from the provider who performed your examination or from a list of participating eyewear providers in your service area. Eyewear supplied by providers other than participating providers are not covered. To locate a participating eyewear provider, call Health Net Cal MediConnect Member Services 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Or you can look one up online at mmp.healthnetcalifornia.com. You will be responsible for payment of non-covered services, such as any amount over your eyewear 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 to your participating eyewear provider. That is all you need to do to get your routine vision exam and new eyeglasses or contact lenses. For a list of Routine Vision and Eyewear exclusions, please see Section F later in this Chapter.

Services that our plan pays for	
	**"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. **Note:** 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. *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*

E. Benefits covered outside of Health Net Cal MediConnect

The following services are not covered by Health Net Cal MediConnect but are available through Medicare or Medi-Cal.

E1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who have lived in an inpatient facility for at least 90 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

You can receive transition coordination services from any CCT Lead Organization that serves the county you live in. You can find a list of CCT Lead Organizations and the counties they serve on the Department of Health Care Services website at: www.dhcs.ca.gov/services/ltc/Pages/CCT.

For CCT transition coordination services:

Medi-Cal will pay for the transition coordination services. You pay nothing for these services.

For services that are not related to your CCT transition:

The provider will bill Health Net Cal MediConnect for your services. Health Net Cal MediConnect will pay for the services provided after your transition. You pay nothing for these services.

While you are getting CCT transition coordination services, Health Net Cal MediConnect will pay for the services that are listed in the Benefits Chart in Section D of this chapter.

No change in Health Net Cal MediConnect drug coverage benefit:

Drugs are not covered by the CCT program. You will continue to get your normal drug benefit through Health Net Cal MediConnect. For more information, please refer to Chapter 5, Section F, page 136.

Note: If you need non-CCT transition care, you should call your care coordinator to arrange the services. Non-CCT transition care is care that is not related to your transition from an institution/facility. To contact your care coordinator, please call Health Net Cal MediConnect at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; for example, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- Root canal therapy
- Dentures, adjustments, repairs, and relines

Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, please contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at dental.dhcs.ca.gov/ for more information.

In addition to the fee-for-service Medi-Cal Dental Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Los Angeles County. If you want more information about dental plans, need assistance identifying your dental plan, or want to change dental plans, please contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

E3. Hospice care

You can get care from any hospice program certified by Medicare. You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Health Net Cal MediConnect pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

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

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

For drugs that may be covered by Health Net Cal MediConnect's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5, Section F3, page 136.

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 prognosis. To contact your care coordinator, please call Health Net Cal MediConnect at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

F. Benefits not covered by Health Net Cal MediConnect, Medicare, or Medi-Cal

This section tells you what kinds of benefits are excluded by the plan. Excluded means that we do not pay for these benefits. Medicare and Medi-Cal will not pay for them either.

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*) except under the specific conditions listed. 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, refer to Chapter 9, Section D, page 197.

In addition to any exclusions or limitations described in the Benefits Chart, 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. Refer to Chapter 3, Section J, page 61 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 necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- 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 necessary.
- 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 coverage guidelines.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- 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.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- 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 and Neuropsychological 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.
- Transcranial Magnetic Stimulation (TMS).
- V-codes as listed in DSM 5.
- Services deemed experimental or investigational by Health Net Cal MediConnect.
- Services received out of your primary state of residence, except in the event of Emergency Services and as otherwise authorized by Health Net Cal MediConnect.
- Electro-Convulsive Therapy (ECT), except as authorized by Health Net Cal MediConnect.
- Routine dental care, such as cleanings, fillings or dentures. However, certain dental services, including dentures, will be provided by the state's Denti-Cal program. See "Dental services" in the Benefits Chart for more information.

Non-Medicare Covered Routine Vision and Eyewear exclusions:

- Radial keratotomy, and LASIK surgery. 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, plano contact lenses (lenses with refractive correction of less than + .50 diopter).
- Two pair of eyeglasses in lieu of bifocals.
- Non-prescription eyewear and sunglasses
- Lens Add-Ons
- 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 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. Also, chapters 5 and 6 have more information about outpatient prescription drugs under your medical or prescription drug benefits.
- Vision aids (other than Eyeglasses or Contact Lenses) or low vision aids as outlined in the Benefits Chart earlier in this chapter.
- 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.
- Vision 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

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, Section D3, page 147 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

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, refer to the Benefits Chart in Chapter 4, Section D, page 70.

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 generally 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.
    - Refer to Chapter 9, Section F2, page 218 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 medical references. For Medi-Cal covered drugs, this means the use of the drug is within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of disease, illness or injury.

Table of Contents

A. Getting your prescriptions filled

A1. Filling 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 use 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.

A2. Using your Member ID Card when you fill a prescription

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

If you do not have your Member 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, refer to Chapter 7, Section A, page 153.
- If you need help getting a prescription filled, you can contact Member Services.

A3. What to do if you 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 there are any refills left.

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

A4. What to do if your pharmacy 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.

A5. Using 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. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network, or you have any difficulty accessing your drug benefits in a long-term care facility, 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.

A6. Using 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 that are not available through the plan's mail order service are marked with "NM" in our Drug List.

Our plan's mail order service allows you to order up to a 90-day supply. A 90-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get order forms and information about filling your prescriptions by mail, visit our website mmp.healthnetcalifornia.com, or call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

Usually, a mail order prescription will get to you within 10-14 days. If your mail order is delayed, call Member Services or CVS Caremark at 1-888-624-1139 (TTY: 711).

Mail order processes

The mail order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail order prescriptions:

1. **New prescriptions the pharmacy gets from you**

   The pharmacy will automatically fill and deliver new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets directly from your provider's office**

   After the pharmacy gets a prescription from a health care provider, it will contact you to find out if you want the medication filled immediately or at a later time.

   - This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped.
   - It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **Refills on mail order prescriptions**

   For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

   - The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
   - If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

   To opt out of our program that automatically prepares mail order refills, please contact us by calling Member Services or your mail order pharmacy:

   CVS Caremark: 1-888-624-1139 (TTY: 711)

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You should verify your contact information each time you place an order, at the time you enroll in the automatic refill program or if your contact information changes.

A7. Getting 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.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay 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. Refer to the section above, page 126 to learn about mail order services.

A8. Using 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:

- You travel outside the plan's service area and need a drug that you can't get at a network pharmacy close to you.
- You need a drug urgently and there is no network pharmacy that is close to you and open.
- You must leave your home due to a federal disaster or other public health emergency.

Generally, we will cover a one-time fill up to a 30-day supply at an out-of-network pharmacy in these situations.

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

A9. Paying 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 copay when you get your prescription. You can ask us to pay you back for our share of the cost.

To learn more about this, refer to Chapter 7, Section A, page 153.

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.

B1. Drugs on the Drug List

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

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

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

B2. How to find a drug 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 mmp.healthnetcalifornia.com. 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.

B3. Drugs that are 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, refer to Chapter 9, Section F5, page 223.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medi-Cal drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Health Net Cal MediConnect for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration (FDA) or supported by certain medical references 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 says that you have to have tests or services done only by them

B4. Drug List cost sharing tiers

Every drug on our Drug List is in one of three cost-sharing tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Tier 1 (Generic Drugs) includes generic drugs. This is the lowest cost sharing tier.
- Tier 2 (Brand Drugs) includes brand drugs and may include some generic drugs. This is the highest cost sharing tier.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescription and over-the-counter (OTC) generic and brand drugs that are covered by Medi-Cal.

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

Chapter 6, Section D3, page 147 tells the amount you pay for drugs in each cost sharing tier.

C. Limits on some drugs

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 prescribe 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, refer to Chapter 9, Section F2, page 218.

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. In most cases, 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 copay 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. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

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 mmp.healthnetcalifornia.com.

D. Reasons 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, page 130, 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.

D1. Getting 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 were in the plan last year.
    - We will cover a temporary supply of your drug **during the first 90 days of the calendar year**.
    - This temporary supply will be for up to 30-days at a retail pharmacy and a 31-day supply at a long-term care pharmacy.
    - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of a 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to our plan.
    - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
    - This temporary supply will be for up to 30-days at a retail pharmacy and a 31-day supply at a long-term care pharmacy.
    - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30-day supply at a retail pharmacy and a 31-day supply of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
    - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- 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 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
    - If your level of care changes, we will cover a temporary 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 temporary 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 temporary supply, we will cover one 31-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 31-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, they can help you ask for one.

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9, Section F2, page 218.

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, but we may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval for a drug. (Prior approval is permission from Health Net Cal MediConnect before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check our up to date Drug List online at mmp.healthnetcalifornia.com **or**
- Call Member Services to check the current Drug List at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. You can talk to your doctor about other options.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9, Section F2, page 218.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking, increase what you pay for the drug, or limit its use, then the change will not affect your use of the drug or what you pay for the drug for the rest of the year.

F. Drug coverage in special cases

F1. 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 copay. 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, refer to Chapter 6, Section D3, page 147.

F2. 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.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4, Section E3, page 114.

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. 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.

G3. Drug management program to help members safely use their opioid medications

Health Net Cal MediConnect has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from certain pharmacies** and/or **from certain doctors**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9, Section F5, page 223.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

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

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.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 three 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 mmp.healthnetcalifornia.com. The Drug List on the website is always the most current.

- Chapter 5 of this *Member Handbook*.
    - Chapter 5, Section A, page 124 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, Section A, page 124.

Table of Contents

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

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary 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.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

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, refer to the Drug List.

B. How to keep 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 Member ID Card.**

   Show your Member 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 copay 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, refer to Chapter 7, Section A, page 153.

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 EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, please call Member Services. Instead of receiving a paper EOB in the mail, you now have the option of receiving an electronic EOB (eEOB). You may request the eEOB by visiting www.caremark.com. If you choose to opt-in, you will receive an email when your eEOB is ready to view, print or download. The eEOBs are also known as paperless EOBs. These eEOBs are exact copies (images) of printed EOBs. Be sure to keep these EOBs. 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 copay. 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, 2022. 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 copay. The copay depends on what cost-sharing tier the drug is in and where you get it.

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

- Tier 1 (Generic Drugs) includes generic drugs. The copay is from $0 to $3.95, depending on your income.
- Tier 2 (Brand Drugs) includes brand drugs and may include some generic drugs. The copay is from $0 to $9.85, depending on your income.
- Tier 3 (Non-Medicare Rx/OTC Drugs) includes some prescription and over-the-counter (OTC) generic and brand drugs that are covered by Medi-Cal. The copay is $0.

D1. 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. Refer to Chapter 5, Section C, page 130 to find out when we will do that.

To learn more about these pharmacy choices, refer to Chapter 5, Section A, page 124 in this handbook and our *Provider and Pharmacy Directory*.

D2. 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, refer to Chapter 5, Section A7, page 127 or the *Provider and Pharmacy Directory*.

D3. What you pay

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

You can contact Member Services to find out how much your copay 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 90-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 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5, Section A8, page 127 for details.
Cost-sharing Tier 1 (Generic Drugs)	$0, $1.35 or $3.95 copay This depends on your level of Medi-Cal coverage.	$0, $1.35 or $3.95 copay This depends on your level of Medi-Cal coverage.	$0, $1.35 or $3.95 copay This depends on your level of Medi-Cal coverage.	$0, $1.35 or $3.95 copay This depends on your level of Medi-Cal coverage.
Cost-sharing Tier 2 (Brand Drugs)	$0, $4 or $9.85 copay This depends on your level of Medi-Cal coverage.	$0, $4 or $9.85 copay This depends on your level of Medi-Cal coverage.	$0, $4 or $9.85 copay This depends on your level of Medi-Cal coverage.	$0, $4 or $9.85 copay This depends on your level of Medi-Cal coverage.
Tier 3 (Non-Medicare Rx/OTC Drugs)	$0 copay	$0 copay	$0 copay	$0 copay

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

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach $7,050. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOBs 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 $7,050 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 $7,050 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

In some cases, you pay a copay 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, the amount you pay will be based on the number of days of the drug that you get. 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 get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you:
  - better plan when to refill your drugs,
  - coordinate refills with other drugs you take, **and**
  - take fewer trips to the pharmacy.

G. Prescription cost-sharing assistance for persons with HIV/AIDS

G1. What the AIDS Drug Assistance Program (ADAP) is

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.

G2. What to do if you aren't enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050 or refer to the ADAP website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

G3. What to do if you're 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 getting 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 1-844-421-7050 or refer to the website listed above.

H. Vaccinations

We cover Medicare Part D vaccines. 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 vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

H1. What you need to know 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.

H2. What you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in Chapter 4, Section D, page 70.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

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

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
   - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
   - You will pay a copay to the doctor for the vaccine.
   - Our plan will pay for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get 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 copay for the vaccine.
   - Our plan will pay for the cost of giving you the shot.

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

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs you already got. 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, refer to Section B, page 156.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid more than your share of the cost, it is your right to be paid back.
- 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. 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 for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. Show your Health Net Cal MediConnect Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills.**

- As a member of Health Net Cal MediConnect, you only have to pay the copay when you get services covered by our plan. We do not allow providers to bill you more than this amount. 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 still 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 the difference between the amount you paid and the amount you owed under the plan.

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

If you use 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 refer to Chapter 5, Section A8, page 127 to learn more about out-of-network pharmacies.

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

If you do not have your Member 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 (refer to Chapter 9, Section F4, page 220).
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9, Section F4, page 220).
- 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, refer to Chapter 9, Section F5, page 223.

B. Sending a 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 (mmp.healthnetcalifornia.com), or you can call Member Services and ask for the form.

Mail your request and proof of payment together with any bills or receipts to us at this address. Please provide an approved type of proof of payment, which can be a copy of a canceled check, a credit or debit card statement or a receipt of a wire transfer:

Medical Claims address:

Health Net Cal MediConnect
Health Net Community Solutions, Inc.
PO Box 9030
Farmington, MO 63640-9030

You must submit your claim to us within one year from the date you got the service or item.

Pharmacy Claims address:

Health Net Cal MediConnect
Part D Prescription Drug Claims
Attn: Pharmacy Claims
PO Box 31577
Tampa, FL 33631-3577

You must submit your claim to us within three years from the date you got the drug.

C. Coverage decisions

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, Section B, page 43 explains the rules for getting your services covered. Chapter 5, Section A, page 124 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, refer to Chapter 9, Section D, page 197.

D. Appeals

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, refer to Chapter 9, Section D, page 197.

- If you want to make an appeal about getting paid back for a health care service, refer to Chapter 9, Section E5, page 214.
- If you want to make an appeal about getting paid back for a drug, refer to Chapter 9, Section F5, page 223.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Your 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.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. If you want to get documents in a different language and/or format for future mailings, please call Member Services. Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) wants to make sure you understand your health plan information. We can send materials to you in another language or alternate format if you ask for it this way. This is called a "standing request." We will document your choice. Please call us if:
    - You want to get your materials in Arabic, Chinese (traditional characters), Farsi, Spanish, Tagalog, Vietnamese or in an alternate format. You can ask for one of these languages in an alternate format.
    - You want to change the language or format that we send you materials.
- You can also get this handbook in the following languages on our website at: mmp.healthnetcalifornia.com or for free simply by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
    - Arabic
    - Chinese
    - Farsi
    - Spanish
    - Tagalog
    - Vietnamese

If you need help understanding your plan materials, please contact Health Net Cal MediConnect Member Services at 1-855-464-3572 (TTY: 711). Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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, 7 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

لديك الحق في الحصول على المعلومات بالطريقة التي تفي باحتياجاتك

يجب علينا إخبارك عن مزايا الخطة وحقوقك بطريقة يمكنك فهمها. ولا بد لنا أن نخبرك بحقوقك سنويًا طالما أنك تشترك معنا في خطتنا.

- **للحصول على المعلومات بطريقة تتمكن من فهمها، اتصل بخدمات الأعضاء. تتضمن خطتنا أشخاصًا ممن يمكنهم الإجابة على الأسئلة بلغات مختلفة.**
- بمقدور خطتنا تزويدك أيضًا بمواد بلغات أخرى غير اللغة الإنجليزية وبصيغ مختلفة مثل الطباعة بأحرف كبيرة أو طريقة برايل أو تسجيل صوتي. إذا كنت ترغب في الحصول على الوثائق بلغة و/أو صيغة أخرى للتمكن من التواصل عبر البريد الإلكتروني فيما بعد، يرجى الاتصال بخدمات الأعضاء. تريد خطة Health Net Cal MediConnect Plan (خطة Medicare-Medicaid) التأكد من أنك تفهم معلومات خطتك الصحية. يمكننا أن نرسل إليك مواد بلغة أخرى أو بصيغة بديلة إذا طلبت ذلك. يُطلق على ذلك "الطلب الدائم". وسنقوم بتوثيق اختيارك. الرجاء الاتصال بنا في حالة:
  - • إذا كنت تريد الحصول على المواد باللغة العربية أو الصينية (بأحرف تقليدية) أو الفارسية أو الإسبانية أو التاغولوغية أو الفيتنامية أو بصيغة بديلة. يمكنك طلب إحدى هذه اللغات بصيغة بديلة.
  - • كنت تريد تغيير اللغة أو الصيغة التي نرسل المواد بها إليك.
- يمكنك أيضًا الحصول على هذا الدليل باللغات التالية على موقعنا الإلكتروني على: mmp.healthnetcalifornia.com أو مجانًا عن طريق الاتصال بخدمات الأعضاء على الرقم 1-855-464-3572 (الهاتف النصي: 711) من الساعة 8 صباحًا حتى 8 مساءً، من الإثنين إلى الجمعة. بعد انتهاء ساعات العمل وفي عطلة نهاية الأسبوع والعطلات يمكنك ترك رسالة. وسنعاود الاتصال بك خلال يوم العمل التالي.
  - اللغة العربية
  - اللغة الصينية
  - اللغة الفارسية
  - اللغة الإسبانية
  - اللغة التاغولوغية
  - اللغة الفيتنامية

إذا كنت بحاجة إلى مساعدة لفهم مواد خطتك، فيرجى الاتصال بخدمات أعضاء Health Net Cal MediConnect على 1-855-464-3572 (الهاتف النصي: 711). ساعات العمل من 8 صباحًا حتى 8 مساءً، من الاثنين إلى الجمعة. بعد انتهاء ساعات العمل وفي عطلة نهاية الأسبوع والعطلات يمكنك ترك رسالة. وسنعاود الاتصال بك خلال يوم العمل التالي.

إذا كنت تواجه صعوبة في الحصول على معلومات من خطتنا نتيجة لمشاكل تخص اللغة أو الإعاقة وتريد تقديم شكوى، فاتصل بـ Medicare على الرقم 1-800-MEDICARE (1-800-633-4227). يمكنك الاتصال على مدار 24 ساعة يوميًا، 7 أيام في الأسبوع. ينبغي على مستخدمي الهاتف النصي الاتصال على الرقم 1-877-486-2048. للحصول على معلومات حول تقديم شكوى إلى Medi-Cal، يُرجى الاتصال بقسم خدمات الأعضاء على الرقم الآتي: 1-855-464-3572 (الهاتف النصي: 711) من الساعة 8 صباحًا حتى 8 مساءً، من الإثنين إلى الجمعة. بعد انتهاء ساعات العمل وفي عطلة نهاية الأسبوع والعطلات يمكنك ترك رسالة. وسنعاود الاتصال بك خلال يوم العمل التالي.

您有權以符合您需求的方式取得資訊

我們必須透過您能夠瞭解的方式告知您有關計劃的福利及您的權利。只要您尚在本計劃中，我們每年皆必須告知您有關您的權利。

- 如欲透過您能夠瞭解的方式取得資訊，請致電會員服務部。本計劃有精通不同語言的人士可為您解答疑問。
- 本計劃也可以為您提供英語以外的語言版本、大字版、點字版或語音版的資訊。若您想要取得其他語言和/或格式的文件以供未來郵寄使用，請致電會員服務部。Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) 想確保您瞭解自己的健保計劃資訊。如果您提出要求，我們可以用其他語言或其他格式向您傳送材料。這被稱為「長期申請」。我們將會記錄您的選擇。如果您有以下要求，請致電我們：
    - 您需要阿拉伯語、中文 (繁體字)、波斯語、西班牙語、塔加洛語、越南語或其他格式的材料。您可以要求用另一種格式提供其中一種語言。
    - 您想變更我們向您傳送材料的語言或格式。
- 您也可以免費獲得本手冊的下列語言版本，方法如下：造訪我們的網站 mmp.healthnetcalifornia.com，或致電會員服務部 1-855-464-3572 (聽障專線：711)，服務時間為週一至週五上午 8 點至晚上 8 點。非營業時間、週末及假日，您可以留言，我們將會在下個工作日回電給您。
    - 阿拉伯語
    - 中文
    - 波斯語
    - 西班牙語
    - 塔加洛語
    - 越南語

如果您需要幫助來瞭解自己的計劃材料，請致電聯絡 Health Net Cal MediConnect 會員服務部，電話是 1-855-464-3572 (聽障專線：711)。服務時間為週一至週五上午 8 點至晚上 8 點。非營業時間、週末及假日，您可以留言，我們將會在下個工作日回電給您。

如果您因語言問題或身心障礙，而在向本計劃取得資訊時遭遇困難，因此想要提出投訴，請致電 Medicare，電話是 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。聽障專線使用者請致電 1-877-486-2048。如需有關向 Medi-Cal 提交投訴的資訊，請聯絡會員服務部，電話是 1-855-464-3572 (聽障專線：711)，服務時間為週一至週五上午 8 點至晚上 8 點。非營業時間、週末及假日，您可以留言，我們將會在下個工作日回電給您。

شما حق دارید اطلاعات را به صورتی دریافت کنید که نیازهای شما را برآورده می‌کند

ما باید مزایای برنامه درمانی و حقوق قانونی شما را به صورتی به شما بگوئیم که برایتان قابل فهم باشد. ما باید هرسال حقوق قانونی که در برنامه ما دارید را به شما بگوییم.

- **برای دریافت اطلاعات به شکلی که برایتان قابل فهم باشد، با مرکز خدمات اعضا تماس بگیرید.**
  برنامه درمانی ما افرادی را در استخدام دارد که می‌توانند به سؤالات به زبان‌های مختلف جواب دهند.

- برنامه ما همچنین می‌تواند مطالبی به همهٔ زبان‌های غیر از انگلیسی و فرمت‌هایی مثل چاپ درشت، خط بریل و فرمت صوتی برای شما فراهم کند. اگر می‌خواهید در آینده این سند را به زبان و/یا فرمت دیگری دریافت کنید، لطفاً با مرکز خدمات اعضا تماس بگیرید. Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) می‌خواهد مطمئن شود که شما اطلاعات برنامه درمانی خود را درک می‌کنید. در صورت درخواست شما، می‌توانیم مطالب را به زبان‌ها یا قالب‌های دیگر برای شما ارسال کنیم. این کار «درخواست دائمی» نامیده می‌شود. ما انتخاب شما را ثبت می‌کنیم. لطفاً در موارد زیر با ما تماس بگیرید:
  - تمایل دارید مطالب را به زبان‌های عربی، چینی (نویسه‌های سنتی)، فارسی، اسپانیایی، تاگالوگ، ویتنامی یا در قالب دیگر دریافت کنید. می‌توانید یکی از این زبان‌ها را در قالب جایگزین درخواست کنید.
  - تمایل دارید زبان یا قالب مطالب ارسالی‌مان به شما را تغییر دهید.

- همچنین می توانید این کتابچه راهنما را به زبان های زیر در وب سایت ما به این آدرس دریافت کنید: mmp.healthnetcalifornia.com یا به صورت رایگان با خدمات اعضا با شماره 1-855-464-3572 (TTY :711) روزهای دوشنبه تا جمعه از 8 صبح تا 8 شب تماس بگیرید. بعد از ساعات اداری یا آخر هفته‌ها و روزهای تعطیل، می‌توانید پیام بگذارید. در روز کاری بعدی با شما تماس گرفته خواهد شد.
  - عربی
  - چینی
  - فارسی
  - اسپانیایی
  - تاگولوگ
  - ویتنامی

چنانچه برای درک مطالب طرح خود نیاز به کمک دارید، لطفاً با مرکز خدمات اعضای Health Net Cal MediConnect به این شماره تماس بگیرید 1-855-464-3572 (TTY: 711) تماس بگیرید. ساعات اداری از 8 صبح تا 8 شب، دوشنبه تا جمعه است. بعد از ساعات اداری یا آخر هفته‌ها و روزهای تعطیل، می‌توانید پیام بگذارید. در روز کاری بعدی با شما تماس گرفته خواهد شد.

اگر به خاطر مشکلات زبانی یا معلولیت، در دریافت اطلاعات از برنامه درمانی ما با مشکل مواجه هستید و می‌خواهید شکایتی را ارائه کنید، با Medicare به شماره 1-800-MEDICARE (1-800-633-4227) تماس بگیرید. می‌توانید در 24 ساعت شبانه‌روز و 7 روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند. جهت اطلاع از شکایت با Medi-Cal، لطفاً با خدمات اعضا به شماره 1-855-464-3572 (TTY: 711) روزهای دوشنبه تا جمعه از 8 صبح تا 8 شب تماس بگیرید. بعد از ساعات اداری یا آخر هفته‌ها و روزهای تعطیل، می‌توانید پیام بگذارید. در روز کاری بعدی با شما تماس گرفته خواهد شد.

Su derecho a obtener información de manera tal que satisfaga sus necesidades

Debemos explicarle los beneficios del plan y sus derechos de una manera que usted pueda comprender. Debemos explicarle sus derechos cada año que tenga la 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 sus preguntas en varios idiomas.
- El plan también puede proporcionarle material en otros idiomas, además del inglés, y en distintos formatos como en braille, en audio o en letra grande. Si quiere recibir los documentos en otro idioma o formato en la correspondencia que se le envíe en el futuro, llame al Departamento de Servicios al Afiliado. En Health Net Cal MediConnect Plan (Medicare-Medicaid Plan), queremos asegurarnos de que usted entiende la información de su plan de salud. Podemos enviarle materiales en otros idiomas o en formatos alternativos si así los solicita. Esto se denomina “solicitud permanente”. Guardaremos su elección. Llámenos en los siguientes casos:
    - Si quiere recibir sus materiales en árabe, chino (caracteres tradicionales), farsi, español, tagalo o vietnamita, o en un formato alternativo. También puede solicitar que se le envíen en uno de estos idiomas y, a su vez, en un formato alternativo.
    - Si quiere cambiar el idioma o el formato en el que le enviamos los materiales.
- También puede obtener este manual en los siguientes idiomas en nuestro sitio web: mmp.healthnetcalifornia.com o, de forma gratuita, llamando al Departamento de Servicios al Afiliado al 1-855-464-3572 (TTY: 711), de lunes a viernes, de 8:00 a. m. a 8:00 p. m. Puede dejar un mensaje fuera del horario de atención, los fines de semana y los días feriados. Lo llamaremos el siguiente día hábil.
    - Arabic
    - Chino
    - Farsi
    - Español
    - Tagalo
    - Vietnamita

Si necesita ayuda para entender los materiales de su plan, comuníquese con el Departamento de Servicios al Afiliado de Health Net Cal MediConnect, al 1-855-464-3572 (TTY: 711). El horario de atención es de lunes a viernes, de 8:00 a. m. a 8:00 p. m. Puede dejar un mensaje fuera del horario

de atención, los fines de semana y los días feriados. Lo llamaremos el siguiente día hábil.

Si tiene dificultades para obtener información de nuestro plan por problemas relacionados con el idioma o una discapacidad y quiere 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 1-855-464-3572 (TTY: 711), de lunes a viernes, de 8:00 a. m. a 8:00 p. m. Puede dejar un mensaje fuera del horario de atención, los fines de semana y los días feriados. Lo llamaremos el siguiente día hábil.

Ang inyong karapatang makakuha ng impormasyon sa isang paraan na tumutugon sa mga pangangailangan ninyo

Dapat naming sabihin sa inyo ang mga benepisyo ng plano at ang inyong mga karapatan sa paraang mauunawaan ninyo. Dapat naming sabihin sa inyo ang tungkol sa inyong mga karapatan bawat taon na nasa plano namin kayo.

- Para makakuha ng impormasyon sa isang paraan na maiintindihan ninyo, tawagan ang Mga Serbisyo para sa Miyembro. Ang aming plano ay mayroong mga tao na makakasagot sa inyong mga tanong sa iba't ibang mga wika.
- Mabibigyan rin kayo ng aming plano ng mga materyales na nasa mga wikang maliban sa Ingles at nasa mga format tulad ng malalaking letra, braille, o audio. Kung gusto ninyong makuha ang mga dokumento sa ibang wika at/o format para sa mga mailing sa susunod na pagkakataon, pakitawagan ang Mga Serbisyo para sa Miyembro. Gustong masiguro ng Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) na nauunawaan ninyo ang impormasyon sa inyong planong pangkalusugan. Maaari kaming magpadala sa inyo ng mga materyal sa ibang wika o alternatibong format kung hihilingin ninyo ito sa ganitong paraan. Tinatawag itong "pangmatagalang kahilingan." Itatala namin ang inyong pinili. Pakitawagan kami kung:
    - Gusto ninyong makuha ang inyong mga materyal sa Arabic, Chinese (mga tradisyonal na karakter), Farsi, Spanish, Tagalog, Vietnamese o sa isang alternatibong format. Maaari ninyong hilingin ang isa sa mga wikang ito sa isang alternatibong format.
    - Gusto ninyong baguhin ang wika o format na ipinadala namin sa inyo sa mga materyal.
- Puwede rin ninyong makuha ang handbook na ito sa mga sumusunod na wika sa aming website sa: mmp.healthnetcalifornia.com o nang libre sa pamamagitan ng pagtawag sa Mga Serbisyo para sa Miyembro sa 1-855-464-3572 (TTY: 711), mula 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Para sa mga oras pagkatapos ng trabaho, Sabado at Linggo at pista opisyal, maaari kayong mag-iwan ng mensahe. May tatawag sa inyo sa susunod na araw na may pasok.
    - Arabic
    - Chinese
    - Farsi
    - Spanish
    - Tagalog

- Vietnamese

Kung kailangan ninyo ng tulong sa pag-unawa sa mga materyal ng inyong plano, makipag-ugnayan sa Mga Serbisyo para sa Miyembro ng Health Net Cal MediConnect sa 1-855-464-3572 (TTY: 711). Ang mga oras na bukas ay mula 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Para sa mga oras pagkatapos ng trabaho, Sabado at Linggo at pista opisyal, maaari kayong mag-iwan ng mensahe. May tatawag sa inyo sa susunod na araw na may pasok.

Kung nahihirapan kayong makakakuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto ninyong maghain ng reklamo, tawagan ang Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kayong tumawag 24 na oras sa isang araw, 7 araw sa isang linggo. Dapat tumawag ang mga gumagamit ng TTY sa 1-877-486-2048. Para sa impormasyon sa paghahain ng reklamo sa Medi-Cal, mangyaring makipag-ugnayan sa Mga Serbisyo para sa Miyembro sa 1-855-464-3572 (TTY: 711), mula 8 a.m. hanggang 8 p.m., Lunes hanggang Biyernes. Para sa mga oras pagkatapos ng trabaho, Sabado at Linggo at pista opisyal, maaari kayong mag-iwan ng mensahe. May tatawag sa inyo sa susunod na araw na may pasok.

Quý vị có quyền nhận thông tin theo cách đáp ứng nhu cầu của quý vị

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 hội 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.

Chương trình của chúng tôi cũng có thể cung cấp cho quý vị các tài liệu bằng ngôn ngữ khác không phải tiếng Anh và bằng các định dạng chẳng hạn như bản in cỡ lớn, chữ nổi braille hoặc âm thanh. Nếu quý vị muốn nhận tài liệu bằng ngôn ngữ và/hoặc định dạng khác để trao đổi thư từ trong tương lai, vui lòng gọi cho bộ phận Dịch vụ hội viên. Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) muốn đảm bảo rằng quý vị hiểu rõ thông tin về chương trình bảo hiểm sức khỏe của quý vị. Chúng tôi có thể gửi cho quý vị các tài liệu bằng ngôn ngữ khác hoặc bằng định dạng thay thế nếu quý vị có yêu cầu. Điều này này được gọi là “yêu cầu thường xuyên”. Chúng tôi sẽ ghi chép lại lựa chọn của quý vị. Vui lòng gọi cho chúng tôi nếu:

  - Quý vị muốn nhận tài liệu bằng tiếng Ả Rập, tiếng Trung (phồn thể), tiếng Farsi, tiếng Tây Ban Nha, tiếng Tagalog, tiếng Việt và/hoặc bằng định dạng thay thế. Quý vị có thể yêu cầu nhiều hơn một trong những ngôn ngữ này trong một định dạng thay thế.
  - Quý vị muốn thay đổi ngôn ngữ hoặc định dạng của tài liệu mà chúng tôi gửi cho quý vị.

- Quý vị có thể nhận cẩm nang này ở các ngôn ngữ dưới đây trên trang web tại: mmp.healthnetcalifornia.com hoặc đơn giản chỉ cần gọi đến bộ phận Dịch vụ hội viên theo số điện thoại 1-855-464-3572 (TTY: 711) từ 8 a.m. đến 8 p.m., thứ Hai đến thứ Sáu. Ngoài giờ làm việc, vào cuối tuần và ngày lễ, quý vị có thể để lại tin nhắn. Sẽ có người phản hồi cuộc gọi của quý vị vào ngày làm việc tiếp theo.
  - Tiếng Ả Rập
  - Tiếng Trung
  - Tiếng Farsi
  - Tiếng Tây Ban Nha
  - Tiếng Tagalog
  - Tiếng Việt

Nếu quý vị cần trợ giúp để hiểu rõ các tài liệu của chương trình, vui lòng liên lạc với bộ phận Dịch vụ

hội viên của Health Net Cal MediConnect theo số 1-855-464-3572 (TTY: 711). Giờ làm việc từ 8 a.m. đến 8 p.m., thứ Hai đến thứ Sáu. Ngoài giờ làm việc, vào cuối tuần và ngày lễ, quý vị có thể để lại tin nhắn. Sẽ có người phản hồi cuộc gọi của quý vị vào ngày làm việc tiếp theo.

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 tình trạng 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, 7 ngày một tuần. Người dùng TTY xin gọi số 1-877-486-2048. Để biết cách điền đơn than phiền với Medi-Cal, vui lòng liên hệ bộ phận Dịch vụ hội viên theo số điện thoại 1-855-464-3572 (TTY: 711) từ 8 a.m. đến 8 p.m., thứ Hai đến thứ Sáu. Ngoài giờ làm việc, vào cuối tuần và ngày lễ, quý vị có thể để lại tin nhắn. Sẽ có người phản hồi cuộc gọi của quý vị vào ngày làm việc tiếp theo.

B. Our responsibility to ensure that you get timely access to covered services and drugs

If you cannot get a timely appointment to receive covered services and your doctor does not think you can wait longer for the appointment, you can call Health Net Cal MediConnect's Member Services Department and they can assist you. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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. You can find more information about what types of providers may act as a PCP and how to choose a PCP in Chapter 3, Section D1, page 46.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- 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.
    - If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- 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 use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3, Section D4, page 51.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to Chapter 1, Section F, page 12.

- You have the right to self-direct care with help from your care team and care coordinator.

Chapter 9, Section E, page 201 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section D, page 197 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

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

Your PHI 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 PHI is used. We give you a written notice that tells about these rights and also explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

In most situations, we do not give your PHI 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 PHI to government agencies that are checking on our quality of care.
- We are required to release PHI by court order.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to federal laws. If we share your information with Medi-Cal, it will also be done according to federal and state laws.

C2. You have a right to look at 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 PHI has been shared with others.

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

Notice of Privacy Practices

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*.** **Effective 08.14.2017**

Covered Entities Duties:
Health Net** (referred to as "we" or "the Plan") is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Health Net is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI. PHI 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.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

****This Notice of Privacy Practices applies to enrollees in any of the following Health Net entities:**

Health Net of California, Inc., Health Net Community Solutions, Inc., Health Net Health Plan of Oregon, Inc., Managed Health Network, LLC and Health Net Life Insurance Company, which are subsidiaries of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved Rev. 04/06/2018

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the following:

- Uses or disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website and in our Member Handbook.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI.

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes. We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

- ***Payment*** - We may use and disclose your PHI to make benefit payments for the healthcare services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:
  - processing claims
  - determining eligibility or coverage for claims
  - issuing premium billings
  - reviewing services for medical necessity
  - performing utilization review of claims

- ***Health Care Operations*** - We may use and disclose your PHI to perform our health care operations. These activities may include:
  - providing customer services
  - responding to complaints and appeals
  - providing case management and care coordination
  - conducting medical review of claims and other quality assessment
  - improvement activities

In our health care operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its health care operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of health care professionals
- case management and care coordination
- detecting or preventing health care fraud and abuse

Group Health Plan/Plan Sponsor Disclosures – 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, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- ***Fundraising Activities*** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their 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 PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

- ***Appointment Reminders/Treatment Alternatives*** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

- ***As Required by Law*** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

- ***Public Health Activities*** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclosure your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

- ***Victims of Abuse and Neglect*** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

- ***Judicial and Administrative Proceedings*** - We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:
    - an order of a court
    - administrative tribunal
    - subpoena
    - summons
    - warrant
    - discovery request
    - similar legal request

- ***Law Enforcement*** - We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

    - court order
    - court-ordered warrant
    - subpoena
    - summons issued by a judicial officer
    - grand jury subpoena

    We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

- ***Coroners, Medical Examiners and Funeral Directors*** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

- ***Organ, Eye and Tissue Donation*** - may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

    - cadaveric organs
    - eyes
    - tissues

- ***Threats to Health and Safety*** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- ***Specialized Government Functions*** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

    - to authorized federal officials for national security and intelligence activities
    - the Department of State for medical suitability determinations
    - for protective services of the President or other authorized persons

- ***Workers' Compensation*** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

- ***Emergency Situations*** – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

- ***Inmates*** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care, to protect your health or safety, or the health or safety of others, or for the safety and security of the correctional institution.

- ***Research*** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI 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.

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.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions -*** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

- ***Right to Request Confidential Communications -*** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies in the following circumstances: (1) the communication discloses medical information or provider name and address relating to receipt of sensitive services, or (2) disclosure of all or part of the medical information or provider name and address could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but your request must clearly state that either the communication discloses medical information or provider name and address relating to receipt of sensitive services or that disclosure of all or part of the medical information or provider name and address could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where your PHI should be delivered.

- ***Right to Access and Received Copy of your PHI -*** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI. If we deny your request, 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 PHI -*** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

- ***Right to Receive an Accounting of Disclosures -*** You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost- based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

- ***Right to File a Complaint -*** If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201 or calling 1-800-368-1019 (TTY: 1-866-788- 4989) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

Right to Receive a Copy of this Notice - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed below.

Health Net Privacy Office

Attn: Privacy Official

P.O. Box 9103

Van Nuys, CA 91409

Telephone: 1-855-464-3572 (TTY: 711)

Fax: 1-818-676-8314

Email: Privacy@healthnet.com

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer
c/o Office of Legal Services
California Department of Health Care Services
1501 Capitol Avenue, MS 0010
P.O. Box 997413
Sacramento, CA 95899-7413

Phone: 1-916-445-4646 or 1-866-866-0602 (TTY/TDD: 1-877-735-2929)

E-mail: Privacyofficer@dhcs.ca.gov

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW **FINANCIAL INFORMATION** ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

> We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect: We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security: We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice: If you have any questions about this notice:

Please **call the toll-free phone number on the back of your ID card** or contact Health Net at 1-855-464-3572 (TTY: 711).

D. Our responsibility to 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. This is a free service to you. You can also get this handbook in the following languages for free:

- Arabic
- Chinese
- Farsi
- Spanish
- Tagalog
- Vietnamese

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

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

- How to choose or change plans
- 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
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network

- 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
- Why something is not covered and what you can do about it, including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

E. Inability of network providers to 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, refer to Chapter 7, Section A, page 153.

F. Your right to leave our Cal MediConnect Plan

No one can make you stay in our plan if you do not want to.

- 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.
- Refer to Chapter 10, Section C, page 251 for more information about when you can join a new Medicare Advantage or prescription drug benefit 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.

G. Your right to make decisions about your health care

G1. Your 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. You have the right to:

- **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.
- **Get a second opinion.** You have the right to go to another doctor before deciding on treatment.
- **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.
- **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.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section D, page 197 tells how to ask the plan for a coverage decision.

G2. Your 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, or a social worker. Organizations that give people information about Medicare or Medi-Cal, such as HICAP (Health Insurance Counseling and Advocacy Program), may also have advance directive forms.
- **Fill it out and sign the form.** The form is a legal document. 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.

G3. 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

You can call the Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697).

H. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section E, page 201 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.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 – or you would like more information about your rights, you can get help by calling:

- Member Services.
- Health Insurance Counseling and Advocacy Program (HICAP) program. For details about this organization and how to contact it, refer to Chapter 2, Section E, page 30.
- The Cal MediConnect Ombuds Program. For details about this organization and how to contact it, refer to Chapter 2, Section I, page 34.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

I. Your right to make recommendations about our member rights and responsibility policy

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy, share your thoughts with us by contacting member services at the number 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

J. Evaluation of new and existing technologies

New technologies include procedures, drugs, biological product, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. Our plan follows Medicare's National and Local Coverage Determinations when applicable.

In the absence of a Medicare coverage determination, our plan assesses new technology or new applications of existing technologies for inclusion in applicable benefits plans to ensure members have access to safe and effective care by performing a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness and review of evidence based guidelines developed by national organizations and recognized authorities. Our plan also considers opinions, recommendations and assessments by practicing physicians, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations, reports and publications of government agencies (for example, the Food and Drug, Administration (FDA), Centers for Disease Control (CDC), National Institutes of Health (NIH).

K. Your 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, refer to Chapters 3, Section B, page 43 and 4, Section D, page 70. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to Chapters 5, Section A, page 124 and 6, Section C, page 145.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member 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.
    - If you have a share of cost with the Medi-Cal program, you will be responsible for paying your share of cost amount before Health Net Cal MediConnect will pay for your Medi-Cal covered services.
    - 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 copay (a fixed amount).Chapter 6, Section D3, page 147 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 refer to Chapter 9, Section D, page 197 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 service area, you cannot stay in this plan.** Only people who live in our service area can get Health Net Cal MediConnect. Chapter 1, Section D, page 11 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. Refer to Chapter 2, Section G, page 32 and Section H, page 33 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)

Introduction

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 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 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 get 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 chapter explains 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. For additional resources to address your concerns and ways to contact them, refer to Chapter 2, Section I, page 34 for more information on ombudsman programs.

Table of Contents

A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medi-Cal approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. 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,” “benefit determination,” “at-risk 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.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow 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, you can always call the Cal MediConnect Ombuds Program. The Cal MediConnect Ombuds Program is an ombudsman program that 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. The services are free. Refer to Chapter 2, Section I, page 34 for more information on ombudsman programs.

You can get help from the Health Insurance Counseling and Advocacy Program

You can also call the Health Insurance Counseling and Advocacy Program (HICAP). 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 HICAP phone number is 1-800-434-0222.

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 at www.medicare.gov.

You can get help from the California Department of Managed Health Care

In this paragraph, the term “grievance” means an appeal or complaint about Medi-Cal services, your health plan, or one of your providers.

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 1-855-464-3572 (TTY: 711) and use your health plan's grievance process before contacting the department. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making 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. Refer to **Section D: "Coverage decisions and appeals"** on page 197.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 242.

D. Coverage decisions and appeals

D1. 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 copays.

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.

D2. 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:

- Call **Member Services** at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- 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.
- 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 1-800-434-0222.
- 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 or billing problems. 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 them 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 by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at mmp.healthnetcalifornia.com/mmp/appeals-grievances.html. The form gives 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. You can ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.
    - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that 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 E on page 201** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
    - You are not getting medical care you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
        - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List with an "NT" are not covered by Part D. Refer to Section F on page 216 for Part D drug appeals.
    - You got medical care or services 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. Refer to Sections G and H on pages 227 and 234.

- **Section F on page 216** 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 our 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 G on page 227** 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 H on page 234** 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 use, please call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

If you need other help or information, please call the Cal MediConnect Ombuds Program at 1-855-501-3077.

E. Problems about services, items, and drugs (not Part D drugs)

E1. 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, including Medicare Part B drugs. Drugs in the Drug List with an "NT" are **not** covered by Part D. Use Section F for Part D drug Appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover medical, behavioral health, or long-term services and supports (LTSS) you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 202 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 204 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 204 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

   What you can do: You can ask us to pay you back. Refer to Section E5 on page 214 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 204 for information on making an appeal.

   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 G or H on pages 227 and 234 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get medical, behavioral health, or certain long-term services and supports (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: 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- You can fax us at: 1-800-743-1655
- You can write to us at:

Health Net Community Solutions, Inc.
Medical Management
21281 Burbank Boulevard
Woodland Hills, CA 91367-6607

How long does it take to get a coverage decision?

After you ask and we get all of the information we need, it usually takes 5 business days for us to make a decision unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we do not give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), 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. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

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 letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

> **The legal term** for "fast coverage decision" is **"expedited determination."**

Asking for a fast coverage decision:

- Start by calling or faxing to ask us to cover the care you want.
- Call us at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day or fax us at 1-800-743-1655.
- Find other details on how to contact us in Chapter 2, Section A, page 21.

You can also ask your provider or your representative to request a fast coverage decision for you.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. 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 ask for a fast coverage decision if your request is about payment for care or an item you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) 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 (or the 72 hour deadline for Medicare Part B prescription drugs) 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 a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 242.

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 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 (read the next section for more information).

E3. 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 disagree with our decision, you can appeal.

In most cases, you must start your appeal at Level 1. If you do not want to first appeal to the plan for a Medi-Cal service, if your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an Independent Medical Review from the Department of Managed Health Care at www.dmhc.ca.gov. Refer to page 204 for more information. If you need help during the appeals process, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plans.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to check 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.

At a glance: How to make a Level 1 Appeal

You, your doctor, 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 (refer to page 192).
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is in process (refer to page 203).
- Keep reading this section to learn about what deadline applies to your appeal.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. For additional details on how to reach us for appeals, refer to Chapter 2, Section A, page 21.
- 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 Community Solutions, Inc.
    Attn: Appeals & Grievances Dept.
    PO Box 10422
    Van Nuys, CA 91410-0422

  - You can submit your request online at: mmp.healthnetcalifornia.com/mmp/appeals-grievances.html
  - You may also ask for an appeal by calling us at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- We will send you a letter 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 www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or our website at mmp.healthnetcalifornia.com/mmp/appeals-grievances.html.

If the appeal comes from someone besides you or your doctor or other provider, we must get 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 60 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. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 appeals” on page 203 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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 we 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 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 (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
- If your problem is about coverage of 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, refer to Section E4 on page 208.

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 (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

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 coverage of 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 coverage of 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, refer to Section E4 on page 208.

When will I hear about a "fast" appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- If we do not give you an answer to your appeal within 72 hours, we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
- If your problem is about coverage of 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, refer to Section E4 on page 208.

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 coverage of 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 coverage of 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, refer to Section E4 on page 208.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service or item that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service or item. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item while your appeal is processing.

E4. 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 our plan.

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) Filing a complaint or Independent Medical Review or (2) State Hearing.

(1) Independent Medical Review

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. 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 can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan 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.

NOTE: If your provider filed an appeal for you, but we do not get your Appointment of Representative form, you will need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care.

You are entitled to both an IMR and a State Hearing, but not if you have already had a State Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. Refer to page 204 for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or 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 our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

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 for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.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 www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.
- Mail or fax your forms and any attachments to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, CA 95814-2725
  FAX: 916-255-5241

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

(2) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. 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 and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Your Hearing Rights" notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page 207 for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State 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 can call the California Department of Social Services at 1-800-952-5253. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review 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 IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription.

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 Hearing, your Medi-Cal benefits for that service or item can continue until a hearing decision is made. You must ask for a hearing **on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld; **or**

- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item until the hearing decision is made.

How will I find out about the decision?

If your Level 2 Appeal was an Independent Medical Review, the Department of Managed Health Care will send you a letter explaining the decision made by the doctors who reviewed your case.

- 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 Hearing. Refer to page 207 for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, the California Department of Social Services will send you a letter explaining its decision.

- If the State 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 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 went to the Medicare Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, 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 get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.

- If the IRE 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 an Independent Medical Review, you can request a State Hearing. Refer to page 206 for information about asking for a State Hearing.

If your Level 2 Appeal was a State 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 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 Hearing on the same issue.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), 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.

Refer to Section I on page 240 for more information on additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for Tier 1 and/or Tier 2 drugs.

If you get a bill that is more than your copay for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: “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 got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for your share of a service or item I paid for?

Remember, if you get a bill that is more than your copay for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is a covered service or item, and we will check if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send your provider our share of the cost for the service or item within 60 calendar days after we get your request. Your provider will then send the payment to you.
- 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 service or item 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 we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 204. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 30 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot 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 (IRE). 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. Refer to Section I on page 240 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 (refer to Section E4 on page 208).

F. Part D drugs

F1. 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 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 E on page 201.

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 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).

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 how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section 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 already got 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.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 218. Also refer to Sections F3 and F4 on pages 219 and 220.	Skip ahead to **Section F4** on page 220.	Skip ahead to **Section F4** on page 220.	Skip ahead to **Section F5** on page 223.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List 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 Drug List.
    - 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 copay 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, refer to Chapter 5, Section C, page 130).
    - 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, we limit 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 copay 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."**

F3. 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 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 F5 on page 223 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.

F4. 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- 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 D on page 197 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.

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 section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, page 153 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 asking for 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.

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 after we get your doctor's statement.

> **The legal term** for "fast coverage decision" is **"expedited coverage determination."**

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 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 that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - 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 response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 242.

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, this means within 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 it.

- 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 your request.
- **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, this means within 72 hours 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 your request.
- **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 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 your request.
- **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**. The letter will also explain how you can appeal our decision.

F5. 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- 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 you 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.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

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 section 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."**

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 F4 on page 220.

> **The legal term** for "fast appeal" is **"expedited redetermination."**

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 that 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. The reviewer will be someone who did not make the original coverage decision.

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 to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **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, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. 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, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **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 or 14 calendar days if you asked us to pay you back for a drug you already bought.
  - 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.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE 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 IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- 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 other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have a right to give the IRE other information to support your appeal.

- The IRE 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 IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

> **The legal term** for an appeal to the IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE 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 IRE 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 (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE 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 IRE 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 (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. 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 covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you 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.”
- 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.

G1. 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 at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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 rights 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.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- 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 that may have been 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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 refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. 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 find out if your planned discharge date is medically appropriate for you. In California, the Quality Improvement Organization is called Livanta.

To make an appeal to change your discharge date call Livanta 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 for 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, refer to Section G4 on page 232.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section E4 on page 208 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Or you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

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 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 fast 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. 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 refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

What if the answer is Yes?

- If the Quality Improvement 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 Quality Improvement 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 Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at 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 as described in the next section.

G3. 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.

In California, the Quality Improvement Organization is called Livanta. You can reach Livanta 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 of receipt of your request for a second review, 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 for your state at 1-877-588-1123 (TTY: 1-855-887-6668) 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 got 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 Improvement 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 Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page 208 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

G4. What happens if you 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 (which is within 60 days or no later than your planned discharge date, whichever comes first), 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 that 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. This means we will give you our decision within 72 hours after you ask for a "fast review."

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.

- **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 got 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 (IRE) 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 J on page 242 tells how to make a complaint.

During the Level 2 Appeal, the IRE 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 IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE 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 IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE 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 IRE 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.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page 208 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H. 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.
- 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.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.” The written notice tells you the date we will stop covering your care and 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.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, 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 J on page 242 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Or call your State Health Insurance Assistance Program at 1-800-434-0222 (TTY: 711). If you are within San Diego County, call 1-858-565-8772 (TTY: 711).

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In California, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-877-588-1123 (TTY: 1-855-887-6668). Information about appealing to the Quality Improvement Organization is also in the “Notice of Medicare Non-Coverage”. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

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.

What should you ask for?

Ask them for a “fast-track appeal.” This is 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, refer to Section H4 on page 238.
- If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section E4 on page 208 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

> **The legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day 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 refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

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 to you and the Quality Improvement Organization 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.

H3. 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.

During the Level 2 Appeal, the Quality Improvement Organization will 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.

In California, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-877-588-1123 (TTY: 1-855-887-6668). 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.

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 for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got 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 a Level 3 Appeal, which is handled by a judge.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section E4 on page 208 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H4. What happens 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.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check that 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.

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.

- It also means that we agree to pay you back for our share of the costs of care you got 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 (IRE) 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 J on page 242 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.

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 Entity.

- The IRE 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 IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE 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 IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section E4 on page 208 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

I. Taking your appeal beyond Level 2

I1. 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. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must 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 or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator'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.

I2. 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 Hearing decision and you want another judge to review it, you may ask for a rehearing and/or seek judicial review.

To ask for 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 get your decision. This deadline can be extended up to 180 days if you have a good reason for being late.

In your rehearing request, state the date you got 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.

J. How to make a complaint

J1. 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.

At a glance*:* How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 246.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

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

- 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."**

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

J2. Internal complaints

To make an internal complaint, call Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must file it **within 60 calendar** days after you had the problem you want to complain about.

- 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.

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. 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. For example, we would notify you that a Medicare related grievance can only be extended for up to 14 calendar days. 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

- Complaints related to Medicare Part D must be made within 60 calendar days after you had the problem you want to complain about. All other types of complaints must be filed with us or the provider within anytime 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, we will send you a letter within 5 calendar days of receiving your complaint letting you know that we received it.

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.

- We answer most complaints within 30 calendar days. If we do not make a decision within 30 calendar days because we need more information, we will notify you in writing. We will also provide a status update and estimated time for you to get the answer.
- 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 are making a complaint because we took extra time to make a coverage decision, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- **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.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: 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 users can call 1-877-486-2048. The call is free.

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 get all the covered services that we must 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. The services are free.

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 urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan's decision about your complaint, or if our plan 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 TDD number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
TTY: 1-800-537-7697
Fax: 1-202-619-3818

You may also have rights under the Americans with Disability Act and under the Unruh Civil Rights Act. You can contact the Cal MediConnect Ombuds Program for assistance. The phone number is 1-855-501-3077.

You can file a complaint with 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 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. To learn more about the Quality Improvement Organization, refer to Chapter 2, Section F, page 31.

In California, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-877-588-1123 (TTY: 1-855-887-6668).

Chapter 10: Ending your membership in our Cal MediConnect plan

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. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. When you can end your membership in our Cal MediConnect plan

You can end your membership in Health Net Cal MediConnect Plan (Medicare-Medicaid Plan) at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Cal MediConnect plan, or moving to Original Medicare.

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 (February 1, in this example).

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. If you leave our plan, you can get information about your:

- Medicare options in the table on Section D1, page 252.
- Medi-Cal services on Section D2, page 244.

You can get more information about how you can end your membership by calling:

- Member Services at 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- State Health Insurance Assistance Program (SHIP), California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.
- Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

NOTE: If you're in a drug management program, you may not be able to change plans. Refer to Chapter 5, Section G, page 137 for information about drug management programs.

B. How to 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 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) 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 247.

C. How to 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 Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. 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. How to get Medicare and Medi-Cal services separately

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.

D1. Ways to get your 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:	**Here is what to do:**
A Medicare health plan, such as a Medicare Advantage Plan or, if you meet eligibility requirements and live within the service area, a Program of All-inclusive Care for the Elderly (PACE)	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For PACE inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Health Net Cal MediConnect when your new plan's coverage begins.
This chart is continued on the next page	

(continued) **2. You can change to:** **Original Medicare with a separate Medicare prescription drug plan** **This chart is continued on the next page**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Health Net Cal MediConnect when your Original Medicare coverage begins.

(continued) **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 do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You will automatically be disenrolled from Health Net Cal MediConnect when your Original Medicare coverage begins.

D2. How to get your 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 ask to end your membership with our Cal MediConnect plan.

- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. 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 Cal MediConnect 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. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Health Net Cal MediConnect, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. Refer to Section A, page 249 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. Other situations when your membership in our Cal MediConnect plan ends

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 later qualify again for Medi-Cal and wish to re-enroll in Health Net Cal MediConnect, you will need to call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users should call 1-800-430-7077. Tell them you want to re-join Health Net Cal MediConnect.
- 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 jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you are not eligible to remain a member on this basis.
    - We must disenroll you if you do not meet this requirement.

If you no longer qualify for Medi-Cal or your circumstances have changed that make you no longer eligible for Cal MediConnect, you may continue to get your benefits from Health Net Cal MediConnect for an additional two-month period. This additional time will allow you to correct your eligibility information if you believe that you are still eligible. You will get a letter from us about the change in your eligibility with instructions to correct your eligibility information.

- To stay a member of Health Net Cal MediConnect, you must qualify again by the last day of the two-month period.
- If you do not qualify by the end of the two-month period, you'll be disenrolled from Health Net Cal MediConnect.

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 Member 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. Rules against asking you to leave our Cal MediConnect plan for any health-related reason

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, 7 days a week.

You should also **call the Cal MediConnect Ombuds Program** at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.

H. Your 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 file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9, Section J, page 242 for information about how to make a complaint.

I. How to 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 1-855-464-3572 (TTY: 711), from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.
- Call the Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Health Net Cal MediConnect. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook.*

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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 laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, or sex. In addition, we don't discriminate or treat you differently because of your ancestry, marital status, gender identity or sexual orientation.

If you want more information or 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 users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights at:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  90 7th Street, Suite 4-100
  San Francisco, CA 94103
  Phone: 1-800-368-1019
  TTY: 1-800-537-7697
  Fax: 1-202-619-3818

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

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 members. We will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

D. Independent contractors

The relationship between Health Net Cal MediConnect 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 health care.

E. 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, for example, filing a claim that contains a false or deceptive statement is guilty of health care plan 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 (TTY: 711). The Fraud Hotline operates 24 hours a day, 7 days a week, 365 days a year. All calls are strictly confidential.

F. Circumstances beyond Health Net Cal MediConnect'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, state of emergency or other similar events not within the control of our plan, 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 current availability of its facilities or personnel.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing 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 Hearing (Refer to Chapter 9, Section E3, page 208 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, Section D, page 197 explains appeals, including how to make an appeal.

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 usually 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 Member ID 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: Refer to “Individualized Care Plan.”

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 get under Medi-Cal.

Care team: Refer to “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 $7,050 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 32 explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech 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 service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

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.

Copay: 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 copays.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of three 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, Section D, page 197 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) 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.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

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 copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $1.35. This means that the amount you pay for your drug is less than $0.05 per day. If you get a 7 days' supply of the drug, your payment will be less than $0.05 per day multiplied by 7 days, for a total payment less than $0.35.

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).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three tiers.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

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: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. 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 or the quality of service provided by your health plan.

Health Insurance Counseling and Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. Chapter 2, Section E, page 30 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.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Health Net Cal MediConnect must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Health Net Cal MediConnect Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand.

Because Health Net Cal MediConnect pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services.

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, including DME supplies and drugs, 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 asked for. 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.

Initial coverage stage: The stage before your total Part D drug expenses reach $7,050. 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 and over-the-counter (OTC) 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 Community Based Adult Services (CBAS) and Nursing Facilities/Sub-Acute Care Facilities (NF/SCF).

Low-income subsidy (LIS): Refer to “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 some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to Chapter 2, Section H, page 33 for information about how to contact Medi-Cal.

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 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. Medically Necessary refers to all covered services that are within reason and needed to protect life, prevent serious illness or disability, or to relieve 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 (refer to “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

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 “dually eligible individual.”

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, or riders, which explain 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. Refer to Chapter 2, Section A, page 21 for information about how to contact Member Services.

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 works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information about the Cal MediConnect Ombuds Program in Chapters 2, Section I, page 34 and 9, Section A, page 195 of this handbook.

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, Section D, page 197 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 use 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.
- 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, Section D4, page 51 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. Refer to the definition for “cost sharing” above.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Part A: Refer to “Medicare Part A.”

Part B: Refer to “Medicare Part B.”

Part C: Refer to “Medicare Part C.”

Part D: Refer to “Medicare Part D.”

Part D drugs: Refer to “Medicare Part D drugs.”

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Health Net Cal MediConnect’s Notice of Privacy Practices for more information about how Health Net Cal MediConnect protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They 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 use your primary care provider before you use any other health care provider.
- Refer to Chapter 3, Section D, page 46 for information about getting care from primary care providers.

Prior authorization: An approval from Health Net Cal MediConnect you must get before you can get a specific service or drug or use an out-of-network provider. Health Net Cal MediConnect may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

- Covered services that need our plan's prior authorization are marked in the Benefits Chart in Chapter 4, Section D, page 70.

Some drugs are covered only if you get prior authorization from us.

- Covered drugs that need our plan's 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.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of 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. Refer to Chapter 2, Section F, page 31 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.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, Health Net Cal MediConnect may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3, Section D, page 46 and about services that require referrals in Chapter 4, Section D, page 70.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4, Section D, page 70 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. Only people who live in our service area can get Health Net Cal MediConnect.

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 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 Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

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.

Nondiscrimination Notice

Health Net Community Solutions, Inc. (Health Net Cal MediConnect Plan (Medicare-Medicaid Plan)) complies with applicable federal civil rights laws and does not discriminate, exclude people or treat them differently on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Health Net Cal MediConnect:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Health Net Cal MediConnect Customer Contact Center at 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711) from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends, and on holidays, you can leave a message. Your call will be returned within the next business day. The call is free.

If you believe that Health Net Cal MediConnect has failed to provide these services or discriminated in another way, you can file a grievance by calling the number above and telling them you need help filing a grievance; the Health Net Cal MediConnect Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD: 1-800-537-7697) if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Multi-Language Insert

Multi-Language Interpreter Services

English: ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Chinese Mandarin: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711)。

Chinese Cantonese: 注意：如果您說中文，您可獲得免費的語言協助服務。請致電 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County)（TTY: 711）。

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Korean: 주의 : 한국어를 사용하시는 경우 , 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711). 번으로 전화해 주십시오 .

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Arabic: ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بالرقم 1-855-464-3571 (Los Angeles County)، 1-855-464-3572 (San Diego County) (TTY: 711).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711). पर कॉल करें।.

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711). まで、 お電話にてご連絡ください。

Farsi: توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

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Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա Ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711)

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Laotian: ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາອັງກິດ, ການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ບໍ່ເສຍຄ່າມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທ 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Ukrainian: УВАГА! Якщо ви не розмовляєте англійською, для вас доступні безкоштовні послуги перекладу. Телефонуйте на номер 1 855 464 3571 (Los Angeles County), 1 855 464 3572 (San Diego County) (TTY: 711).

Mien: DONGH EIX: Da'faanh Meih Zoux Maiv Qiex English, Janx-kaeqv waac Tengx gong, cing Nauv Maiv fih hnangv, Yiem longx nyei kungx nyei Tuiv Meih. Heuc 1-855-464-3571 (Los Angeles County), 1-855-464-3572 (San Diego County) (TTY: 711).

Health Net Cal MediConnect Member Services

CALL	1-855-464-3572 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., Monday through Friday. After hours, on weekends and on holidays, you can leave a message. Your call will be returned within the next business day.
FAX	1-800-281-2999
WRITE	Health Net Community Solutions, Inc. PO Box 10422 Van Nuys, CA 91410-0422
WEBSITE	mmp.healthnetcalifornia.com