Anthem

Your guide to your 2023 benefits

Evidence of Coverage

Anthem MediBlue Full Dual Advantage (HMO D-SNP)

Member services:
1-833-707-3129 TTY: **711**

www.anthem.com/ca

Anthem MediBlue Full Dual Advantage (HMO D-SNP) *Member Handbook*

January 1 – December 31, 2023

Your Health and Drug Coverage under Anthem MediBlue Full Dual Advantage (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2023. 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 your *Member Handbook*.

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

When this *Member Handbook* says "we," "us," "our," or "our plan," it means Anthem MediBlue Full Dual Advantage (HMO D-SNP).

ATTENTION: If you speak If you speak English, Spanish, Chinese, Vietnamese, Tagalog, Korean, Armenian, Persian, Russian, Arabic, Cambodian, language assistance services, free of charge, are available to you. Call **1-833-707-3129** (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. The call is free.

ATENCIÓN: Si usted habla español, tiene a su disposición servicios gratuitos de asistencia de idiomas. Llame al **1-833-707-3129** (TTY: **711**), de lunes a viernes, de 8:00 a. m. a 8:00 p. m. La llamada es gratuita.	Spanish
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 **1-833-707-3129** (TTY: **711**)，週一至週五上午 8：00-晚上 8：00。通話免費。	Chinese
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ, miễn phí, cho quý vị. Xin gọi số **1-833-707-3129** (TTY: **711**), Thứ Hai đến Thứ Sáu từ 8:00 sáng đến 8:00 tối. Cuộc gọi được miễn tính cước phí.	Vietnamese

Tagalog

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo nang walang bayad ang mga serbisyo ng tulong sa wika. Tumawag sa **1-833-707-3129** (TTY: **711**), Lunes hanggang Biyernes, 8:00 a.m. hanggang 8:00 p.m. Libre ang tawag.

Korean

안내**:** 한국어를 사용할 경우 무료 언어 지원 서비스를 이용하실 수 있습니다**.** 월요일부터 금요일까지 오전 8시에서 오후 8시 사이에 **1-833-707-3129** (TTY: **711**)번으로 전화하십시오**.** 통화료는 무료입니다**.**

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. եթե դուք խոսում եք հայերեն լեզվով, ձեզ համար մատչելի են անվճար լեզվական աջակցության ծառայությունները: Զանգահարեք **1-833-707-3129** (TTY՝ **711**) հեռախոսահամարով, երկուշաբթիից ուրբաթ օրերին, ժամը 8:00-ից 20:00-ը: Այս զանգն անվճար է:

Persian (Farsi)

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به صورت رایگان، برای شما در دسترس می باشد. دوشنبه تا جمعه، از 8:00 صبح تا 8:00 شب با شماره (TTY: **711**) **1-833-707-3129** تماس بگیرید. این تماس رایگان می باشد.

Russian

ВНИМАНИЕ: если вы говорите по-русски, вам могут предоставить бесплатные услуги перевода. Звоните по тел. **1-833-707-3129** (TTY: **711**) с понедельника по пятницу с 8:00 до 20:00. Звонок бесплатный.

Arabic

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوفر لك مجانًا. اتصل على الرقم (TTY: **711**) **1-833-707-3129**، من الاثنين حتى الجمعة من الساعة 8:00 صباحًا حتى 8:00 مساءً. وتكون المكالمة مجانية.

Cambodian (Khmer)

សូមជ្រាបៈ ប្រសិនបើលោកអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយភាសាមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរសព្ទមកលេខ **1-833-707-3129** (TTY: **711**) ពីថ្ងៃច័ន្ទ ដល់ថ្ងៃសុក្រ ពីម៉ោង 8:00 ព្រឹក ដល់ម៉ោង 8:00 ល្ងាច។ ទូរសព្ទមកលេខនេះគឺឥតគិតថ្លៃ។

You can get this document for free in other formats, such as large print, braille, and/or audio. Call **1-833-707-3129** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. The call is free. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at shop.anthem.com/medicare/ca.

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Disclaimers

- Anthem Blue Cross is an HMO D-SNP plan with a Medicare contract and a contract with the California Medicaid program. Enrollment in Anthem Blue Cross depends on contract renewal. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Anthem MediBlue Full Dual Advantage (HMO D-SNP) Plan Member Handbook.
- Using opioid medications to treat pain for more than seven days has serious risks like - addiction, overdose, or even death. If your pain continues, talk to your doctor about alternative treatments with less risk. Some choices to ask your doctor about are: Non opioid medications, acupuncture, or physical therapy to see if they are right for you. Find out how your plan covers these options by calling Member Services at **1-833-707-3129** (TTY: **711**).
- Coverage under Anthem MediBlue Full Dual Advantage (HMO D-SNP) 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 Anthem MediBlue Dual Advantage (HMO D-SNP), a health plan that covers all of your Medicare services and coordinates all of your Medi-Cal services. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Welcome to our plan

Our plan provides Medicare and Medi-Cal services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.

Anthem Blue Cross has served Californians for more than 75 years. At Anthem Blue Cross, we're dedicated to delivering better care to our members, providing greater value to our customers, and helping to improve the health of our communities.

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 to 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 is eligible,
- 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 the state of California approved our plan. 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 is not affected.

C. Advantages of our plan

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

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

- You can work with us for **all** of your health care needs.
- You 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 have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Anthem MediBlue Full Dual Advantage (HMO D-SNP): In most instances you will be enrolled in Anthem MediBlue Full Dual Advantage (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Anthem MediBlue Full Dual Advantage (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Anthem MediBlue Full Dual Advantage (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at **1-833-707-3129** (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. if you have any questions.

D. Our plan's service area

Our service area includes Los Angeles and Santa Clara counties.

Only people who live in our service area can join our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

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 (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **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**
- Are a United States citizen or are lawfully present in the United States.

Call Member Services for more information.

Please note: if you lose your eligibility but can reasonably be expected to regain eligibility within three months, then you are still eligible for membership in our plan (Chapter 4, Section A tells you about coverage and cost sharing during this period, which is called deemed continued eligibility).

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

When you first join our plan, you get a health risk assessment (HRA) within 90 days after your effective enrollment date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. 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. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If they are not in our network, 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 asks us to let you keep using your current provider.
- We 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 our plan.
    - We determine an existing relationship by reviewing your available health information available or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services not included in our plan. You **cannot** make this request for providers of DME, transportation or other ancillary providers.

After the continuity of care period ends, you will need to use doctors and other providers in the Anthem MediBlue Full Dual Advantage (HMO D-SNP) network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to **Chapter 3** of your *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

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

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS needs.

Your care plan includes:

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They talk with you about services you need. They also tell you about services you may want to think about getting. Your care plan is based on your needs. Your care team works with you to update your care plan at least every year.

H. Monthly plan premium

Our plan has no monthly plan premium.

I. Your *Member Handbook*

Your *Member Handbook* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* on our website at the web address at the bottom of the page or download it.

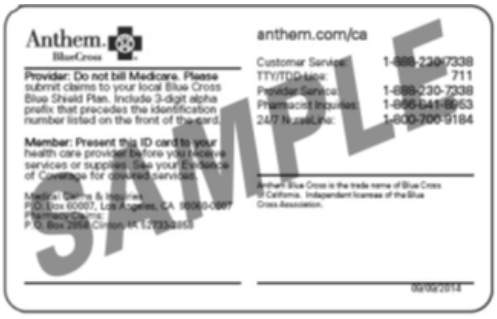
The contract is in effect for the months you are enrolled in our plan between January 1 and December 31, 2023.

J. Other important information you get from us

Other important information we provide to you includes your 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 Plan ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services covered by our plan, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or Part D prescriptions. Here is a sample Member ID Card:



If your Member ID Card is damaged, lost, or stolen, call Member Services right away at the number at the bottom of the page. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card. Keep this card in a safe place, in case you need it later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access the following services:

- 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 our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at shop.anthem.com/medicare/ca.

The *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 Center services and Home Health providers) you may see as a

member of our plan. We also list the pharmacies you may use to get your prescription drugs.

Definition of network providers

- Our 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 agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree 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 the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Durable Medical Equipment (DME)

With this *Member Handbook*, we sent you our List of Durable Medical Equipment. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your *Member Handbook* to learn more about DME equipment.

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 our plan covers.

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** of your *Member Handbook* for more information.

Each year, we 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, call Member Services or visit our website (refer to the information at the bottom of the page).

J4. The *Explanation of Benefits*

When you use your Part D prescription drug benefits, we 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, spent on your Part D prescription drugs and the total amount we paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. **Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you**.

Tell us right away about the following:

- Changes to your name, your address, or your phone number.
- Changes to 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 from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Member Handbook*.

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 our plan and your health care benefits. You can also use this chapter to get information about how to contact your care coordinator and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Member Services

CALL	**1-833-707-3129** This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30
WRITE	P.O. Box 60007 Los Angeles, CA 90060-0007
WEBSITE	shop.anthem.com/medicare/ca

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- 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 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** of your *Member Handbook*.

- 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 or disagree with the decision.
    - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook*.
- 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 our 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**).
    - You can call us and explain your complaint at 1-833-707-3129.
    - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above **– Section F**).
    - You can send a complaint about our plan 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 our plan to the Ombuds Program by calling 1-888-452-8609.
    - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your Medicare covered drugs
    - A coverage decision about your Medicare drugs is a decision about:
        - your benefits and Medicare covered drugs **or**
        - the amount we pay for your Medicare drugs.
    - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

  - For more on coverage decisions about your Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.

- Appeals about your Medicare drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your Medicare drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your Medicare prescription drugs.
  - If your complaint is about a coverage decision about your Medicare prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan 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 Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or Medicare 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** of your *Member Handbook*.
  - 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** of your *Member Handbook*.

B. Your Care Coordinator

At Anthem MediBlue Full Dual Advantage, you will have the support of a care coordinator to assist you before, during and after a health event.

When you become an Anthem MediBlue Full Dual Advantage member, you will be assigned to a 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 care you need.
- A care coordinator will reach out to you to make sure you have what you need.
- If you enter the hospital, a care coordinator can help arrange for services that make it possible to recover at home.
- If you feel that you could use the help of a care coordinator, you can contact Member Services and ask to speak to a care coordinator
- If you are not comfortable with your care coordinator, you can call Member Services at 1-833-707-3129 (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. to find a care coordinator to meet your needs.

CALL	**1-833-707-3129**This call is free. Monday through Friday from 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English.
TTY	TTY: **711** 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 from 8 a.m. to 8 p.m.
WRITE	P.O. Box 60007 Los Angeles, CA 90060-0007
WEBSITE	shop.anthem.com/medicare/ca

Contact your care coordinator to get help with:

- 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).

Long-term services and supports (LTSS) are a variety of services and supports that help elderly individuals and individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation.

LTSS are usually provided in homes and communities, but also in facility-based settings such as nursing facilities. Certain eligibility requirements must be met to qualify for these programs. Call your care coordinator for details and to help you apply.

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.

C. Nurse Advice Call Line

The Nurse Advice Call Line is there to address your health care questions and concerns. The Nurse Advice Call Line can help relieve your worries or help you determine if you should see your doctor. Sometimes you will have health questions late at night, on the weekends or on holidays. No matter what day or time it is, you can talk to a nurse by calling the Nurse Advice Call Line. You can contact the Nurse Advice Call Line with questions about your health or health care.

CALL	1-800-224-0336 This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Available 24 hours a day, 7 days a week

D. Behavioral Health Crisis Line

CALL	1-800-854-7771 This call is free. Available 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Available 24 hours a day, 7 days a week

Contact the Behavioral Health Crisis Line for help with:

Questions about behavioral health and substance abuse services

o Screening

o Assessment

o Referral

o Crisis Counseling

For questions regarding your specialty mental health services, refer to **Section K**.

E. 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	1-800-824-0780 Monday through Friday from 8:30 a.m. to 4:30 p.m.
WRITE	520 S. La Fayette Park Place, Suite 214 Los Angeles, CA 90057
WEBSITE	www.healthcarerights.org

Contact HICAP for help with:

- Questions about our plan or Medicare
- 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. Quality Improvement Organization (QIO)

Our state has an organization called Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). 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 LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com

Contact Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for help with:

- Questions about your health care rights
- 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. 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	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 documents 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 and review the information with you.

H. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, foster care, pregnant women, and individuals with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed by state and federal government.

CALL	1-844-580-7272 Monday through Friday, 8 a.m. to 6 p.m.
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	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov/

I. The Office of the Ombudsman

The Office of the Ombudsman 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 Office of the Ombudsman can also help you with service or billing problems. The Office of the Ombudsman will not automatically take sides in a complaint. They consider all sides in an impartial and objective way. It is their job to help develop fair solutions to health care access problems. Their services are free.

CALL	1-888-452-8609 This call is free. Monday through Friday, between 8:00 a.m. and 5:00 p.m.
TTY	711 This call is free.
WRITE	California Department of Healthcare Services Office of the Ombudsman 1501 Capitol Mall MS 4412 PO Box 997413 Sacramento, CA 95899-7413
EMAIL	MMCDOmbudsmanOffice@dhcs.ca.gov
WEBSITE	www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx

J. County Social Services

If you need help with your Los Angeles or Santa Clara county benefits, contact your local County Social Services Department.

LOS ANGELES	
CALL	1-888-944-4477This call is free. Monday through Friday from 8 a.m. to 5 p.m.
WRITE	IHSS Applications 2707 S. Grand Avenue Los Angeles, CA 90007
WEBSITE	https://dpss.lacounty.gov/en.html
SANTA CLARA	
CALL	1-877-962-3633 This call is free. Monday through Friday from 8 a.m. to 5 p.m.
WRITE	1888 Senter Road San Jose, CA 95112
WEBSITE	www.sccgov.org/sites/ssa/Pages/default.aspx

K. 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	1-800-854-7771 This call is free. 24 hours a day, 7 days a week, including holidays We have free interpreter services for people who do not speak English.
TTY	711 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

Contact the county specialty mental health plan for help with:

- Questions about behavioral health services provide by the county
  - o Eligibility assessment
  - o Referrals
  - o Appointments
  - o General information about available services

L. 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 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

The Health Consumer Alliance Ombuds Program (HCA) offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.

If you have problems with:

- Medi-Cal
- Medicare
- Your health plan
- Accessing medical services
- Appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- Medical billing
- IHSS (In-Home Supportive Services)

Health Consumer Alliance assists with complaints, appeals, and hearings. The phone number for the Health Consumer Alliance is 1-888-804-3536.

Chapter 3: Using our 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 our plan. 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 if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. Information about services and providers

Services are health care (such as doctor visits and medical treatment), long-term services and supports (LTSS), supplies, behavioral health services (including mental health and wellness), 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 in **Chapter 4** of your *Member Handbook*. Covered prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care. 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 our plan. These providers agree 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 services our plan covers

Our plan covers Medicare services and covers or coordinates all Medi-Cal services. This includes behavioral health and long-term services and supports (LTSS).

Our plan will coordinate health care services, behavioral health services, and LTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit.** This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another provider**.** As a plan member, you must choose a network provider to be your PCP.
    - In most cases, your network PCP ***or*** our plan must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't

get approval, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists.

- If you choose a PCP that is part of an independent practice association (IPA) or medical group, the specialists, ancillary providers and hospitals available to you may be limited to only those contracted with the PCP's IPA or medical group. 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 (for more information about this, refer to section D1 in this chapter).

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services furnished from providers outside of the network. Here are some cases when this rule does not apply:

  - We cover emergency or urgently needed care from an out-of-network provider (for more information about this, refer to section H in the chapter.

  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider; however, prior authorization may be required. In this situation, we cover the care at no cost to you.

  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.

  - When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your *Member Handbook*. 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. After 12 months, we no longer cover your care if you continue to use providers that are not in our network.

New members to Anthem MediBlue Full Dual Advantage (HMO D-SNP): In most instances you will be enrolled in Anthem MediBlue Full Dual Advantage (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Anthem MediBlue Full Dual Advantage (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Anthem MediBlue Full Dual Advantage (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at **1-833-707-3129** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. if you have any questions.

C. Your care coordinator

C1. What a care coordinator is

A care coordinator is a clinician or other trained person who works for our plan to provide case manager services for you. Case managers partner with patients to get the care they need to be healthy.

A case manager helps patients:

- Understand how their current health is doing
- Create a care plan just for them
- Get the care they need from our plan and their community
- Become part of managing their own health
- Work with health care workers as a team
- Meet their goals of getting healthy

C2. How you can contact your care coordinator

Contact your care coordinator by calling Member Services. In many situations, the care coordinator may provide you with their direct contact information.

C3. How you can change your care coordinator

If you would prefer to be seen by a different care coordinator, call Member Services to share your concerns and ask for another care coordinator.

D. Care from providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care. If you choose a PCP that is part of an independent practice association (IPA) or medical group, the specialists, ancillary providers and hospitals available to you may be limited to only those contracted with the PCP's IPA or medical group.

Definition of a PCP and what a PCP does do for you

Your PCP is your main health care provider. You'll see your PCP for your regular checkups. If you get sick, your PCP will be the first person you contact. He or she will prescribe medicines for you and give you referrals to specialists or other providers if needed.

Your PCP can be:

- A family doctor
- OB/GYN
- Specialist who gives primary care
- A local health department or similar community clinic

Your choice of PCP

Your relationship with your PCP is important. So when you choose your PCP, try to think about the reasons below to help you. When you choose a PCP, you should:

- Choose a provider that you use now, **or**
- Choose a provider that someone you trust has suggested, **or**
- Choose a provider that is close to your home.

When you enroll with Anthem MediBlue Full Dual Advantage (HMO D-SNP), you will select a PCP by using our *Provider and Pharmacy Directory*. PCPs are listed by city and county, so you can find one close to where you live or work. The directory also shows you what languages are spoken in the PCP's office. If you need help choosing a PCP, call Member Services at **1-833-707-3129** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

When you select your PCP, you are also choosing the hospital(s) and specialty network(s) associated with your PCP. When you choose a PCP, you will be referred to the specialists, hospitals and other providers associated with your PCP and/or medical group

The name and phone number of your PCP is printed on your membership card.

For help in selecting a PCP, you can also call Member Services at **1-833-707-3129** (TTY: 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

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 network, we can help you find a new PCP in our network.

To change your PCP, call Member Services at **1-833-707-3129** (TTY: 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. When you call, be sure to tell Member Services if you are using a specialist or getting other services that need your PCP's approval. Some of these services may be home health services and durable medical equipment.

You can start using your PCP on the first day of the month after your request. For example, if you ask to change your PCP on September 13, you can start using your new primary care doctor on October 1.

We'll send you a new Anthem Blue Cross Cal MediConnect Plan Member ID Card with your new PCP's name and phone number. **Services you can get without approval from your PCP**

In most cases, you 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 getting approval from your PCP first:

- 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 a network provider (for example, if you're outside our plan's service area or during the weekend).

Note: Urgently needed care must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're 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 eligible to get services from Indian health providers, you may use these providers without a referral.

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, such as:

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

If you need specialist care, your PCP will give you a referral to the right doctor or other health care provider who can give you the kind of care you need.

- For some services, you might need prior authorization. Prior authorization means that you need approval from us before you can get a certain service or drug. Your doctor or other health care provider will ask for prior authorization for services they feel you need. To find out which services need prior authorization, refer to the Benefits Chart in Chapter 4.

- Your PCP may only work with a certain hospital or group of specialists. This is why you have to get a referral from your PCP before you-use a specialist. If you

have questions about the specialists or hospitals your PCP works with, contact your PCP or Member Services.

It is very important to get a referral (approval in advance) before you use an Anthem MediBlue Full Dual Advantage (HMO D-SNP) contracted specialist or receive specialty services (with the exception of those services listed above under Section D). If you do not have a referral (approval in advance) before you receive services from a specialist, you may have to pay for these services yourself. Please refer to Section D for information about which services require referrals and/or prior authorizations.

If a specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) from your PCP, Extensivist, Nurse Practitioner or specialist covers more visits to that specialist. Otherwise, you must get another referral (approval in advance) for the additional visits to the specialist.

In addition, PCPs have certain specialists and hospitals they use for referrals, so the PCP you select usually determines the specialists and hospitals you are referred to. If there is a particular contracted specialist or facility you prefer, check first to be sure your PCP sends patients to that specialist or uses that hospital.

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We 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 work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.

- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Contact Member Services at **1-833-707-3129** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

D4. Out-of-network providers

In most cases, we will not cover care you receive from an out-of-network provider. This means that your care was from a provider who is not part of our plan's network. There are times when we will cover care from an out-of-network provider. Here are three cases when we will cover your care from an out-of-network provider:

- If you need emergency or urgent care. For more information about this, and to see what emergency or urgent care means, refer to Emergency care or Urgently needed care in the Benefits Chart in Chapter 4.

- If you need medical care that Medicare says our plan must cover but none of our network providers offer this type of care. In this case, your PCP or Specialist will need to get a "Prior Authorization." This means that Anthem MediBlue Full Dual Advantage (HMO D-SNP) must approve this before you get the care. If you have approval ahead of time you will pay the same you would pay if you got the care from a network provider. It is very important to get your referral from your PCP, Specialist or Extensivist approved before you use an out-of-network provider. If you do not have a referral before you receive care from an out-of-network provider, you may have to pay for these services yourself.

- Kidney dialysis services that you get at a Medicare-certified dialysis center when you are outside the plan's service area for a short time.

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. Behavioral health (mental health and substance use disorder) services

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare. Our plan does not provide Medi-Cal covered behavioral health services, but these services are available to you through The Los Angeles County Department of Mental Health (LACDMH and The Santa Clara County Mental Health Department and the Department of Alcohol and Drug Services.

E1. Medi-Cal behavioral health services provided outside our plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by The Los Angeles County Department of Mental Health (LACDMH and The Santa Clara County Mental Health Department and the Department of Alcohol and Drug Services include:

- Mental health services
- 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

Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through The Los Angeles County Department of Mental Health (LACDMH and The Santa Clara County Mental Health Department and the Department of Alcohol and Drug Services if you meet criteria to receive these services. Drug Medi-Cal services provided by The Los Angeles County Department of Mental Health (LACDMH and The Santa Clara County Mental Health Department and the Department of Alcohol and Drug Services include:

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

Drug Medi-Cal Organized Delivery System Services include:

- Outpatient and intensive outpatient services
- Medications for addiction treatment (also called Medication Assisted Treatment)
- Residential/inpatient
- Withdrawal management
- Narcotic treatment services
- Recovery services
- Care coordination

In addition to the services listed above, you may have access to voluntary inpatient detoxification services if you meet the criteria.

If you feel you need any of these services, talk to your case manager or your PCP. Your case manager or provider will ask you questions to find out the kinds of services you need and help you pick a provider. You might need a referral or prior authorization (meaning you need permission from us) to get the services. Once you get the referral and/or prior authorization, you or your case manager can make an appointment.

F. Transportation services

F1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need non-emergency medical transportation, you can talk to your PCP and ask for it. Your PCP will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they will prescribe it by completing a form and submitting it to Anthem MediBlue Full Dual Advantage (HMO D-SNP) for approval. Depending on your medical need, the approval is good for one year. Your PCP will reassess your need for non-emergency medical transportation for re-approval every 12 months.

Non-emergency medical transportation is an ambulance, litter van, wheelchair van, or air transport. Anthem MediBlue Full Dual Advantage (HMO D-SNP) allows the lowest cost covered transportation mode and most appropriate non-emergency medical transportation for your medical needs when you need a ride to your appointment. For example, if you can physically or medically be transported by a wheelchair van, Anthem MediBlue Full Dual Advantage (HMO D-SNP) will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your PCP because you are not able to use a bus, taxi, car, or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle, or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Anthem MediBlue Full Dual Advantage (HMO D-SNP) at **1-844-923-0744** (TTY: **711**) at least 48 hours (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Medical transportation limits

Anthem MediBlue Full Dual Advantage (HMO D-SNP) covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation will not be provided if Medicare or Medi-Cal does not cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, Anthem MediBlue Full Dual Advantage (HMO D-SNP) will help you schedule your

transportation. A list of covered services is in Chapter 4 of this handbook. Transportation is not covered outside Anthem MediBlue Full Dual Advantage (HMO D-SNP)'s network or service area unless pre-authorized.

F2. Non-medical transportation

Non-medical transportation benefits include traveling to and from your appointments for a service authorized by your provider. You can get a ride, at no cost to you, when you:

- Traveling to and from an appointment for a -service authorized by your provider, or
- Picking up prescriptions and medical supplies.

Anthem MediBlue Full Dual Advantage (HMO D-SNP) allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. Anthem MediBlue Full Dual Advantage (HMO D-SNP) uses American Logistics. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Anthem MediBlue Full Dual Advantage (HMO D-SNP) must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling Member Services. **You cannot be reimbursed for driving yourself**.

Mileage reimbursement requires all of the following:

- The driver's license of the driver
- The vehicle registration of the driver
- Proof of car insurance for the driver

To ask for a ride for services that have been authorized, call Anthem MediBlue Full Dual Advantage (HMO D-SNP) at **1-844-923-0744** (TTY: **711**), 8 a.m. to 8 p.m., Monday to Friday. at least 48 hours (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Note: American Indians may contact their local Indian Health Clinic to ask for non-medical transportation.

Non-medical transportation limits

Anthem MediBlue Full Dual Advantage (HMO D-SNP) provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

Non-medical transportation does **not** apply if:

- An ambulance, litter van, wheelchair van, or other form of non-emergency medical transportation is needed to get to a service.
- You need assistance from the driver to and from the residence, vehicle, or place of treatment due to a physical or medical condition.
- You are in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service is not covered by Medicare or Medi-Cal.

G. Covered services in a medical emergency, when urgently needed, or during a disaster

G1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or 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 have a medical emergency:

- **Get help as fast as possible.** Call 911 or use to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories worldwide, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We will 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 won't pay for emergency services if you delay in telling us. For more information call Member Services at **1-833-707-3129** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. You can find this information on the back of your Member ID Card.

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.

Anthem MediBlue Full Dual Advantage (HMO D-SNP) offers limited supplemental emergency medical care coverage for occasions when you are outside of the United States. Please refer to the Benefits Chart in Chapter 4 for more details.

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. 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** of your *Member Handbook.*

This plan covers emergency services if you're traveling outside of the United States for less than six months. Coverage is limited to $100,000 per year for worldwide emergency services. This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over $100,000 and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency. $0 copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit. If you need emergency

care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 1-800-810-BLUE (1-800-810-2583). Or call collect at 1-804-673-1177. We can help you 24 hours a day, seven days a week, 365 days a year.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. 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. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.

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 may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules (refer to Section H2) for getting it.

G2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

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

If it is not possible or reasonable to get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Urgently needed service coverage is worldwide.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

This plan covers emergency services if you're traveling outside of the United States for less than six months. Coverage is limited to $100,000 per year for worldwide emergency services. This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over $100,000 and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency. $0 copay for each covered worldwide urgently needed service. If you need urgent care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 1-800-810-BLUE (1-800-810-2583). Or call collect at 1-804-673-1177. We can help you 24 hours a day, 7 days a week, 365 days a year. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines.

G3. 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 our plan.

Visit our website for information on how to get care you need during a declared disaster: shop.anthem.com/medicare/ca.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

H. What to do if you are billed directly for services our plan covers

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

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

If you got a bill for covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

H1. What to do if our plan does not cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Member Handbook*) **and**
- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we 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 of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you use over the limit, you pay the full cost to get more of that type of service. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

I. Coverage of health care services in a clinical research study

I1. 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. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

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

We encourage you to tell us before you take part 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 take part in a clinical trial.

I2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays 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're covered for most services and items 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're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

I3. 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.

J. How your health care services are covered in a religious non-medical health care institution

J1. 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 cover care in a religious non-medical health care institution. This benefit is only for Medicare Part A inpatient services (non-medical health care services).

J2. 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:
    - 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.

Medicare Inpatient Hospital coverage limits apply. For more information, please see the Benefits Chart in Chapter 4.

K. Durable medical equipment (DME)

K1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider such as 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 always own certain items, such as prosthetics.

In this section, we discuss DME you rent. In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you will **not** own DME, no matter how long you rent it.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

K2. DME ownership if you switch to Original Medicare

If you didn't get ownership of the DME item while in our plan, you must make 13 new consecutive payments after you switch to Original Medicare to own the item. Payments you made while in our plan do **not** count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare **before** you joined our plan, your previous payments don't count toward the 13 consecutive payments. You must make 13 new consecutive payments after you return to Original Medicare to own the item. There are no exceptions to this case when you return to Original Medicare.

K3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- 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.

K4. Oxygen equipment when you switch to Original Medicare

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you 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:

- Oxygen equipment, supplies, and services for another 24 months.

- 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 rent from a supplier for 36 months.
- Your supplier then provides 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.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan 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 your *Member Handbook*.

New members to Anthem MediBlue Full Dual Advantage (HMO D-SNP): In most instances you will be enrolled in *Anthem MediBlue Full Dual Advantage (HMO D-SNP)* for your Medicare benefits the 1st day of the month after you request to be enrolled in *Anthem MediBlue Full Dual Advantage (HMO D-SNP)*. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through **Anthem Medi-Cal**. There will be no gap in your Medi-Cal coverage. Please call us at **1-844-309-6996** (TTY: **711**) if you have any questions.

Table of Contents

A. Your covered services

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

Because you get assistance from Medi-Cal, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Member Handbook* for details about the plan's rules.

If you need help understanding what services are covered, call Member Services at 1-844-309-6996 (TTY: 711).

B. Rules against providers charging you for services

We don't allow our in-network 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** of your *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart 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 requirements described below.

- We must provide your Medicare and Medi-Cal covered services 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 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.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we do **not** pay for care you get from an out-of-network provider. **Chapter 3** of your *Member Handbook* 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 a provider that is not your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.
- You must get care from providers that are affiliated with your PCP's medical group. Refer to **Chapter 3** of your *Member Handbook* for more information.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization. We mark covered services in the Benefits Chart that need prior authorization with a note.
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.
- Medicare approved Anthem to provide these benefits and/or lower copayments/coinsurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

  Important benefit information for all enrollees participating in Wellness and Health Care Planning (WHP) services

  Because Anthem MediBlue Full Dual Advantage (HMO D-SNP) participates in certain Value Based Insurance Design benefits (benefits are marked in the Medical Benefits Chart by a footnote), you will be eligible for the following WHP services, including advance care planning (ACP) services:

  An online advance care planning resource called, MyDirectives® . This resource helps you to create an advance directive where you can combine the elements of a: • Living will– decisions on what medical treatments you would or would not like to receive • Medical power of attorney – designation of one or more healthcare

agents who can make medical decisions for you if you are not able to • Organ donation form • And more, including religious preference statements − You can create a new digital care plan on MyDirectives® or, if you already have these documents prepared, you can upload them so that they can be more easily shared with those that may need access to it. MyDirectives® is available to you and your designated medical providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change. − To get started, log into your Anthem MediBlue Full Dual Advantage (HMO D-SNP) member portal and go to the Programs Dashboard and select Advance Directive Programs. It will take you to MyDirectives® to create a new account, or link your existing account. − Participation in any programs that include Wellness and Healthcare Planning or Advance Care Planning are voluntary and you are free to decline the services at any time.

Important benefit information for all enrollees: Because you receive "Extra Help" to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you are eligible for other targeted supplemental benefits and/or targeted reduced cost sharing. **Members in this plan will pay nothing for their Part D covered drugs** through all stages of the Part D coverage.

- All preventive services are free. You find this apple 🍎 next to preventive services in the Benefits Chart.
- ***Community Supports****: Community Supports may be available under your Individualized Care Plan.* Community Supports are medically appropriate and cost-effective alternative services or settings. These services are optional for members. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. Examples of community supports that we offer include:
    - **Community transition to a home:** For members living in NF who want to safely transition to the community and need assistance doing so
    - **Day habilitation:** Skills training in financial management, employment support, daily living skills, etc. to ensure stability in the community
    - **Home modifications** that can help a member stay in their home such as ramps and grab bars in the shower

- **Housing deposits:** Completing payment for security deposits, utility deposits, and other types of payments to gain housing; member must also participate in housing transition navigation
- **Housing tenancy and sustaining:** Upon becoming housed, supporting member in remaining housed
- **Housing transition and navigation:** Completing a housing support plan to identify barriers to housing, helping in a housing search, working with landlords, and any other activities to facilitate housing placement
- **Medical respite:** Up to 90-day placement for people who are homeless or with unstable living situations who are too ill or frail to recover in their usual living environment, and in need of clinical oversight (med management or administration, activities of daily living (ADL) assistance), but do not necessarily require nursing facility (NF) level of care
- **Medically tailored meals or medically supportive food:** Up to two meals a day or vouchers for health food for members who have a clinical need for special diet and no other resources to help them prepare meals
- **Nursing facility diversion or transition to assisted living facilities (ALF):** Members in the community at risk for NF placement or currently live in a NF, and assisting them in finding an ALF to live in
- **Personal care:** Supplemental personal care hours for people waiting on In-Home Supportive Services (IHSS) to start, or in addition to IHSS for certain circumstances Environmental accessibility:
- **Respite:** For members with informal caregivers who are at risk of being unable to provide informal care without a break
- **Short-term post-hospitalization housing:** Up to 180-day placement for people who are homeless and need clinical oversight; member will be offered housing transition navigation services
- **Sobering center:** short term, no more than 24-hour, placement in lieu of emergency room or jail for intoxicated persons to become sober, and connect with substance use disorder (SUD) services}
- **Asthma remediation:** Ensure safety in home to prevent asthma being exacerbated

- If you need help or would like to find out which Community Supports may be available for you, call 1-844-309-6996 (TTY: 711) or call your health care provider.

D. Our plan's Benefits Chart

Services that our plan pays for		What you must pay
	Abdominal aortic aneurysm screening We 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.	$0
	Acupuncture – Medicare Covered **For chronic lower pain back** Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is 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 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. **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay
	Medicare-covered acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Talk to your provider and get a referral and/or prior authorization. **Acupuncture – Supplemental** This plan covers unlimited supplemental acupuncture visits per year.	

Services that our plan pays for		What you must pay
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening (SABIRT) 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. **Sobering center:** short term, no more than 24-hour, placement in lieu of emergency room or jail for intoxicated persons to become sober, and connect with substance use disorder (SUD) services Talk to your provider and get a referral and/or prior authorization.	$0
	Ambulance services Covered ambulance services include ground, fixed-wing, and rotary-wing (helicopter) 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.	$0

Services that our plan pays for		What you must pay
	Annual wellness visit You should get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Annual Routine Physical Exam** In addition to the "Welcome to Medicare" exam or the annual wellness visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases.	$0 $0
	Asthma Preventive Serivces You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.	$0
	Bone mass measurement We 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 pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0
	Breast cancer screening (mammograms) We 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	$0

Services that our plan pays for		What you must pay
	Cardiac (heart) rehabilitation services We 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. Talk to your provider and get a referral and/or prior authorization.	$0
🍎	**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.	$0
🍎	**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.	$0

Services that our plan pays for		What you must pay
	Cervical and vaginal cancer screening We 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	$0
	Chiropractic services We pay for the following services: • Manual mainpulation of the spine to correct subluxation. Additional services may be available. Contact your Care Coordinator for assistance. Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	Colorectal cancer screening For people 50 and older, we 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.	$0
	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 pay for CBAS if you meet the eligibility criteria. **Note:** If a CBAS facility is not available, we can provide these services separately.	$0

Services that our plan pays for		What you must pay
	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 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 face-to-face counseling 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 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.	$0

	Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental xrays) are not covered by Original Medicare. You must use a provider that is part of the Anthem MediBlue Dual Advantage (HMO D-SNP) medical network. You can find these providers in the Provider Directory. To learn more, call Member Services. **Dental services – Supplemental** This plan provides additional dental coverage not covered by Original Medicare. This plan covers: 2 oral exam(s), 2 cleaning(s), 1 dental X-ray(s), 1 fluoride treatment(s) every year. The above preventive dental services are limited to the following: - D0120 Periodic oral evaluation -D0150 Comprehensive oral evaluation - D1110 Prophylaxis, adult - D0210 Intraoral, complete series of radiographic images - D0330 Panoramic radiographic image - D1208 Topical application of fluoride, excluding varnish This plan covers up to a **$1,500.00** allowance for covered comprehensive dental services every year. Any amount not used at the end of the calendar year will expire. Our comprehensive dental allowance can be used toward any dental service, including but not restricted to: Additional exams, cleanings and x-rays, deep teeth cleanings, fluoride treatments, fillings and repairs, root canals (Endodontics), dental crowns (Caps), bridges and implants, dentures, extractions, and other services.	$0

Services that our plan pays for		What you must pay
	To be covered in-network, you need to use a provider that is contracted with our dental vendor to provide supplemental dental services. Care rendered by a provider that is not part of our supplemental dental network is not covered. Talk to your provider and get a referral and/or prior authorization. Additional benefits may be available through Medi-Cal. Contact your Care Coordinator for details.	
	Depression screening We 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.	$0
	Diabetes screening We 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.	$0

Services that our plan pays for		What you must pay

🍎	**Diabetic self-management training, services, and supplies**
	
	We 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 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)
	• In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.
		$0

	Doula Services For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery.	$0

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies Refer to the last chapter of your *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • Wheelchairs, including electric 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. With this *Member Handbook*, we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at shop.anthem.com/medicare/ca. **This benefit is continued on the next page**	$0 This plan covers one blood glucose monitor every calendar year. Blood glucose test strips are covered for a maximum dose of 100 units every 30 days for patients who had a claim for insulin within the last 180 days. Blood glucose test strips are covered for a maximum dose of 50 units every 30 days for patients who have not had a claim for insulin within the last 180 days. Lancets are covered for 100 units every 30 days and up to 300 units for a 90 day supply.

	Durable medical equipment (DME) and related supplies (continued) Generally, our plan covers any DME covered by Medicare and Medi-Cal from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to **Chapter 9** of your *Member Handbook*. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website. If you receive a durable medical equipment item during an inpatient stay in a hospital or skilled nursing facility, the cost will be included in your inpatient claim. Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will not be covered. **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (continued) Coverage limitations: -2 Sensors per month -One receiver every 2 years Insulin pumps are different than a CGM and can be purchased through a DME provider Your provider must get our approval for items such as powered vehicles, powered wheelchairs and related items, and wheelchairs and beds that are not standard. Your provider must also get approval for therapeutic continuous glucose monitors covered by Medicare. This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. We will not cover other brands unless your provider tells us it is medically necessary Talk to your provider and get a referral and/or prior authorization.	

Services that our plan pays for		What you must pay

	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.
	
	World Wide Emergency Care:
	
	This plan covers emergency services if you're traveling outside of the United States for less than six months.
	
	Coverage is limited to $100,000 per year for worldwide emergency services. This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over $100,000 and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency.If you need emergency care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 1-800-810-BLUE (1-800-810-2583). Or call collect at 1-804-673-1177. We can help you 24 hours a day, seven days a week, 365 days a year.
		$0
		
		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 our plan approvs your stay.
		
		$0 copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit.

	Essential Extras You may only choose two (2) of the supplemental benefits per year below: • Assistive Devices: $500 every year • Flex Account - Dental, Vision, Hearing: $500 every year • Flex Account - Utilities: $50 every month • Healthy Groceries: $50 every month • In-Home Support: 60 hours every year • Transportation: 60 one-way trips every year See below for benefit descriptions You pay nothing for the two (2) Essential Extras supplemental benefit options you have chosen. **Assistive Devices[1]:** This benefit provides an annual allowance towards the purchase of assistive devices on a prepaid credit card. Covered items allowed by Medicare include, but are not limited to: ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair ramps, and more. The credit card is prepaid by the plan with the allowance amount. You can only pay for your own services and cannot convert the card to cash. Any unused funds will expire at the end of the year and cannot be rolled over into the following year. Here are the ways to access your benefit: • Place orders online. • Call to place an order. Pick items by shopping online or from the Assistive Device catalog. Have your product name(s) and Assistive Device benefit card number ready. You can select in-store pick up or home delivery. Note: • Once the annual amount is used, you are responsible for any remaining costs. **This benefit is continued on the next page**	$0

	Essential Extras (continued) • Any repair or replacement of items selected is limited to the manufacturer's warranty. • Items are limited to those offered within the catalog and subject to availability. • Items must be primarily for your use only. • Items are limited to those offered within the catalog and subject to availability. • Quantity limits may apply. • Installation services are not included. **Flex Account - Dental, Vision, Hearing[1]:** The Flex Account - Dental, Vision, Hearing benefit is a prepaid credit card that may be used to reduce your annual out-of-pocket expenses for any dental, vision, and/or hearing services as described in those sections of this chart. The card may be used to pay your dental, vision, or hearing provider directly for any out-of-pocket expenses you incur. The credit card is prepaid by the plan with the allowance amount. You can only pay for your own services and cannot convert the card to cash. Cosmetic procedures are not covered under this benefit. Any unused funds will expire at the end of the year and cannot be rolled over into the following year. **Flex Account - Utilities[1]:** Flex Account – Utilities is a prepaid credit card with an allowance that may be used to reduce your out-of-pocket expenses for utilities such as natural/propane gas, electric, water, sewer, broadband, and cellular costs. The card may be used to cover these expenses when provided by any utility provider that accepts a prepaid credit card. **This benefit is continued on the next page**	

	Essential Extras (continued) The credit card is prepaid by the plan with the allowance amount. You can only pay for your own services and cannot convert the card to cash. The card cannot be used to set up automated recurring transactions. Any unused funds will expire at the end of the month and cannot be rolled over into the following month. If your provider does not accept a prepaid credit card for payment or in the event of a card transaction failure, you may submit a claim form for reimbursement along with proof of payment. Claims must be submitted within 90 days of the date of payment. **Healthy Groceries[1]:** Healthy Groceries provides you with an allowance towards the purchase of healthy food items using a benefit card at participating retailers. Some items, including tobacco and alcohol products, are excluded. Any unused amounts will expire at the end of the month. Unused amounts do not roll over to the following month. Here are the ways to access your benefit: 1. Shop in stores 2. Place orders online 3. Call to place an order Note: • All Purchases must be placed through the plan's approved retailers. • Once you reach your monthly allowance, you are responsible for the remaining cost of your purchases • Orders delivered through the mail are limited to one order per month and must be for at least $35. **This benefit is continued on the next page**	

	Essential Extras (continued) **In-Home Support[1]:** This benefit provides companionship and assistance with independent activities of daily living such as home-based chores, support to appointments or obtaining items outside the home such as groceries or medication, and more. In-home support can work in conjunction with other benefits or care plans to promote independent living, aid in reducing a member's feeling of social isolation, and improve their overall mental outlook. You must use the plan approved provider. **Transportation[1]:** This benefit covers one-way trips to locations within the local service area (60-mile limit per one-way trip) when obtaining plan-covered services. You can go to the pharmacy after your doctor's appointment to pick up prescriptions. This will not count as a separate trip. When you schedule a pick-up from the visit, tell the vendor that you need to go to the pharmacy. Ask the provider/facility to call in the prescription so you have a shorter wait. This stop will not count as a separate trip. You must use the plan approved vendor and schedule trips 48 business hours in advance. **How to select your Essential Extras Benefits:** You can select your benefit(s) either via the member portal or by contacting Member Services. For the benefit(s) to be covered, you must use an approved provider. You may be able to make a one- (1-) time per year change to your initial election if you have not used any part of your benefit(s) and would like to select a different option. You will receive a confirmation letter within 7 business days of your election(s) with benefit(s) details. If you have any questions, please contact Member Services. [1]Value-Based Insurance Design benefit	

Services that our plan pays for		What you must pay
	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 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 also pay for some other family planning services. However, you must use 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	$0

	Fitness programs **Fitness Tracker** A health and wellness device designed to promote an active lifestyle focusing on physical activity and accountability for health outcomes with activities supported by a fitness tracker. Limit is one device every two years. Members must obtain from a contracted provider. **Flex Account – Active Fitness** This plan covers a $25.00 per month allowance for the payment of access fees for fitness and recreational classes/programs provided by sports fitness facilities such as golf courses, swimming pools, and tennis courts where access fees apply. Any unused funds will roll over from month to month but do not roll over to the next calendar year. **SilverSneakers** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations. You have access to instructors who lead specially designed group exercise classes. At participating locations nationwide, you can take classes plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live, SilverSneakers OnDemand™ and our mobile app, SilverSneakers GO™. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET.	$0

Services that our plan pays for		What you must pay
	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 • Flex Account-Active Fitness see Fitness programs for details • Fitness Tracker – see Fitness programs for details • SilverSneakers® Fitness Program - see Fitness programs for more details	$0
	Healthy meals You may be eligible for a meal program to assist you in maintaining a healthy diet to support your medical condition or nutritional needs. This benefit provides up to 180 healthy, prepared meals delivered directly to your home each year. For fastest qualification, your provider is best suited to request this on your behalf. Alternatively, you can contact Member Services or your care coordinator and a representative will help validate that you qualify for the benefit and arrange for you to be contacted to complete a nutritional assessment and schedule delivery of your meals. For us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements. Note: We are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone.	$0

	Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. For in-network Medicare-covered hearing care, you must use a doctor in the Anthem MediBlue Full Dual Advantage (HMO D-SNP) specialty medical network. You can find them in the Provider Directory. To learn more, call the Member Services number on the back cover of this booklet. Talk to your provider and get a referral and/or prior authorization. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Please contact your care coordinator for details. **Hearing services – Supplemental** This plan provides additional hearing coverage not covered by Original Medicare. This plan covers 1 routine hearing exam(s) and hearing aid fitting/evaluation(s) every year. $3,000.00 maximum plan benefit for prescribed hearing aids every year. The Plan has negotiated rates and options through our hearing aid supplier to give you the most options. You must select a device from the covered list available through our participating hearing aid supplier. Hearing Aids may require prior authorization from our hearing supplier. If members choose a device with non-rechargeable batteries, the plan will provide a 2- year supply (up to 64 cells per ear, per year). To learn more, call Member Services. After plan paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Please contact your care coordinator for details.	$0

Services that our plan pays for		What you must pay
🍎	**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 also pay for additional HIV screening(s) when recommended by your provider.	$0
	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 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	$0

Services that our plan pays for		What you must pay
	Home infusion therapy Our plan pays 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. Our plan covers 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. Talk to your provider and get a referral and/or prior authorization.	$0 Home Infusion Therapy (HIT) professional services furnished by a qualified HIT supplier in the patient's home. $0 Durable Medical Equipment (DME) - includes the external infusion pump, the related supplies, and the infusion drug(s) by a contracted DME provider.

	Hospice care 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. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider. Our plan pays for the following while you get hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **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 our plan but not covered by Medicare Part A or B:** • Our plan covers services not covered under Medicare Part A or B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*. **Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	$0

Services that our plan pays for		What you must pay
	Immunizations We 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 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines, such as the Shingles vaccine, that meet the Medicare Part D coverage rules. We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).	$0
	Inpatient hospital care We pay for the following services and other medically necessary services not listed here: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies **This benefit is continued on the next page**	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.

Services that our plan pays for		What you must pay
	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 if 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 our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • Blood, including storage and administration • Physician services	

Services that our plan pays for		What you must pay
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is 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 pay for services you get in an Institute for Mental Diseases (IMD). Talk to your provider and get a referral and/or prior authorization.	$0
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We do not pay for your inpatient stay if it is not reasonable and medically necessary. However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We 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 **This benefit is continued on the next page**	$0

Services that our plan pays for		What you must pay

	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued)
	• 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**
	  ○ 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 your condition
	• Physical therapy, speech therapy, and occupational therapy	

Services that our plan pays for		What you must pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We 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** of your *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're 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, refer to "Medicare Part B prescription drugs" in this chart.	$0

Services that our plan pays for		What you must pay
	Lung cancer screening Our plan pays for lung cancer screening every 12 months if you: • Are aged 50-77, **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, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0
	Meals- Post Discharge After you are discharged from an inpatient stay at a hospital or skilled nursing facility, you may qualify for nutritious, precooked, frozen meals delivered to you at no cost. After an overnight stay at a hospital or skilled nursing facility, you may be contacted by the plan or one of its representatives, to see if you would like this benefit. Alternatively, you or your provider/care coordinator can contact Member Services after your discharge and a representative will help validate that you qualify for the benefit and arrange for you to be contacted to complete a nutritional assessment and schedule delivery of your meals. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Please contact your Care Coordinator for details.	$0 Up to 2 meals a day for 7 days following your discharge from the hospital or skilled nursing facility (SNF).

Services that our plan pays for		What you must pay
	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 pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	$0
	Medicare Community Resource Supports Although your plan benefits are designed to cover what Medicare would cover, as well as some additional supplemental benefits as described in this grid, you might need additional help. As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. The Medicare Community Resource Support team will assist you by providing information and education about community-based services and support programs in your area. To access this benefit, call Member Services and ask for the Medicare Community Resource Support team.	

Services that our plan pays for		What you must pay
	Medicare Diabetes Prevention Program (MDPP) Our plans pays 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.	$0

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • 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. We pay for these drugs 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 **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 • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. **Chapter 5** of your *Member Handbook* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Member Handbook* explains what you pay for your outpatient prescription drugs through our plan.	$0

Services that our plan pays for		What you must pay
	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 pay for include, but are not limited to, the following: • Semiprivate room (or a private room if 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**	$0

Services that our plan pays for		What you must pay
	Nursing facility care (continued) • Hearing exams • Chiropractic care • Podiatry services You 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.	
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we 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.	$0

Services that our plan pays for		What you must pay
	Opioid treatment program (OTP) services Our plan pays 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) Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	$0

Services that our plan pays for		What you must pay
	Outpatient diagnostic tests and therapeutic services and supplies We 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 Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	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 o Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." o Sometimes you can be in the hospital overnight and still be "outpatient." o You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/media/11101 • 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 Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	Outpatient mental health care We 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 pay for the following services, and maybe other services not listed here: • Clinic services • Day treatment • Psychosocial rehab services • Partial hospitalization or 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 Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	Outpatient rehabilitation services We 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. Talk to your provider and get a referral and/or prior authorization.	$0
	Outpatient substance abuse services We 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 Talk to your provider and get a referral and/or prior authorization.	$0
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Talk to your provider and get a referral and/or prior authorization.	$0

	Over-the-counter (OTC) supplemental coverage This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$200 every quarter.** Unused OTC amounts do roll over to the next quarter. Unused OTC amounts do not roll over to the next calendar year. Additional services may be covered in accordance with your Medi-Cal RX benefits and guidelines. Contact your care coordinator for details. Over-the-Counter (OTC) items are drugs and health related products that do not need a prescription. More than 1,000 OTC items are covered by this plan, as allowed by Medicare. Covered items include: • Toothpaste • Eye drops • Nasal spray • Vitamins • Cough drops • Pain relievers • Antacids • First aid items • And more... Approximately 14 business days after enrollment, you will receive a Welcome Kit containing your benefit card, catalog and information on how to begin using the benefit, so you can start shopping for covered products. Here are the ways to access your benefit: 1. Place orders online through the web or the smartphone mobile application for in-store pick up or home delivery. 2. Shop in stores using your OTC benefit card at more than 4,600 Walmart stores and other participating retailers.	$0

Services that our plan pays for		What you must pay
	3. Call to place an order. Pick items by shopping online or from the OTC catalog. Have your product names, OTC benefit card number and delivery information ready. **Note:** Purchases are limited to the available benefit dollars. After plan paid OTC benefits, you are responsible for the remaining cost. Orders delivered through the mail are limited to one order per quarter. No limits on the number of In-store purchases other than the maximum quarterly allowance. Unused amounts will roll over to the next quarter, but not to the next year. All orders must be placed through the plans approved retailer or purchased at a participating retail store. Specific name brands may not be available and quantities may be limited or restricted. Please contact Member Services or your care coordinator if you have questions about this benefit.	
	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 there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. Talk to your provider and get a referral and/or prior authorization.	$0

Services that our plan pays for		What you must pay
	Personal emergency response system (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the Plan with a contracted vendor. The Personal Emergency Response System benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). Please call Member Services for more information or to request the unit.	$0

	Physician/provider services, including doctor's office visits
	
	We pay for the following services:
	• Medically necessary health care or surgery services given in places such as:
	  o Physician's office
	  o Certified ambulatory surgical center
	  o Hospital outpatient department
	• Consultation, diagnosis, and treatment by a specialist
	• Basic hearing and balance exams given by your primary care provider ***or*** specialist, if your doctor orders them to find out whether you need treatment
	• Certain telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare.
	  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.
	• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare
	• 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 at home
	• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke
	• Telehealth services for members with a substance use disorder or co-occurring mental health disorder
	
	This benefit is continued on the next page
		$0

	Physician/provider services, including doctor's office visits (continued)
	• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
	  ○ You have an in-person visit within 6 months prior to your first telehealth visit
	  ○ You have an in-person visit every 12 months while receiving these telehealth services
	  ○ Exceptions can be made to the above for certain circumstances
	• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.
	• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**
	  ○ You're not a new patient **and**
	  ○ The check-in isn't related to an office visit in the past 7 days **and**
	  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
	• 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 **and**
	  ○ The evaluation isn't related to an office visit in the past 7 days **and**
	  ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
	• 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	

Services that our plan pays for		What you must pay
	• Non-routine dental care. Covered services are limited to: ○ Surgery of the jaw or related structures ○ Setting fractures of the jaw or facial bones ○ Pulling teeth before radiation treatments of neoplastic cancer ○ Services that would be covered when provided by a physician	
	Podiatry services We 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 **Podiatry services – Supplemental** This plan covers additional foot care services not covered by Original Medicare: Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet. Prior authorization may be required	$0
	Prostate cancer screening exams For men age 50 and older, we pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0

Services that our plan pays for		What you must pay
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We 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 was removed or impaired as a result of disease, injury, or congenital defect • Incontinence cream and diapers We pay for some supplies related to prosthetic devices. We 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 chart for details.	$0
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have referral for pulmonary rehabilitation from the doctor or provider treating the COPD. We pay for respiratory services for ventilator-dependent patients.	$0

Services that our plan pays for		What you must pay
	Sexually transmitted infections (STIs) screening and counseling We 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 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 pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care We 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 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	$0

Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays 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	$0

Services that our plan pays for		What you must pay
	Transportation: Non-emergency medical transportation This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with 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** Depending on the service, prior authorization may be required.	$0
	Transportation: Non-medical transportation This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs. This benefit does not limit your non-emergency medical transportation benefit.	$0

Services that our plan pays for		What you must pay
	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 can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).	$0

Services that our plan pays for		What you must pay
	Video doctor visits LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready – you'll need it to answer some questions. **Sign up for Free:** You must enter your health insurance information during enrollment, so have your member ID card ready when you sign up. Benefits of a video doctor visit: The visit is just like seeing your regular doctor face-to-face, but just by web camera. It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. The doctor can send prescriptions to the pharmacy of your choice, if needed. If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and see a therapist or psychologist in four days or less. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan.	$0

Services that our plan pays for		What you must pay
	Vision care We pay for the following services: • One routine eye exam every year **and** • Up to $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses every two years. We 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 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 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. **Vision – Supplemental** This plan covers up to $300.00 for eyeglasses or contact lenses every year. We cover more vision care than what Medicare covers, but you must use a doctor in our vision network. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Please contact your care coordinator for details.	$0

Services that our plan pays for		What you must pay
	"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.	$0

E. Benefits covered outside of our plan

We don't cover the following services, but they are available through Original Medicare or Medi-Cal fee-for service.

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 get 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 pays for the transition coordination services. You pay nothing for these services.

For services not related to your CCT transition

The provider bills us for your services. Our plan pays for the services provided after your transition. You pay nothing for these services.

While you get CCT transition coordination services, we pay for services listed in the Benefits Chart in **Section D**.

No change in drug coverage benefit

The CCT program does **not** cover drugs. You continue to get your normal drug benefit through our plan. For more information, refer to **Chapter 5** of your *Member Handbook*.

Note: If you need non-CCT transition care, call your care coordinator to arrange the services. Non-CCT transition care is care **not** related to your transition from an institution or facility.

E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; includes but is not limited to, 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, 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, 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.

Note: Our plan offers additional dental services. Refer to the Benefits Chart in **Section D** for more information.

E3. Hospice care

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. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay 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 bills Medicare for your services. Medicare pays 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 our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook*.

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

F. Benefits not covered by our plan, Medicare, or Medi-Cal

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medi-Cal do not for them either.

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

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay

for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

- Services considered not "reasonable and medically necessary," according Medicare and Medi-Cal standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* 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 medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- 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 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.
- 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.

Chapter 5: Getting your outpatient prescription drugs

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

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include 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** of your *Member Handbook*.

Rules for our plan's outpatient drug coverage

We 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, which must be valid under applicable state law. 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. Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medicaid lists, State Medicaid Exclusion List and State Sanctioned or any similar State Medicaid lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on our 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 to learn about asking for an exception.

- Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

5. Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help you identify medical references to support the requested use of the prescribed drug.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

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

A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for your Medicare Part D covered prescription drug. You may need to pay the pharmacy a copay when you pick up your prescription.

Remember, you need your Medi-Cal card or Benefits Identification Card (BIC) to access Medi-Cal Rx covered drugs.

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

If the pharmacy can’t get the necessary information, you may have to pay the full cost of the prescription when you pick it up, then you can ask us to pay you back.

If you can’t pay for the drug, state and federal law permit the pharmacy to issue no less than a 72-hour supply of your needed prescription in an emergency. Contact Member Services right away. We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services or your care coordinator.

A3. What to do if you change your network pharmacy

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

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan’s network, you need to find a new network pharmacy.

To find a new network pharmacy, 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. Our plan will cover home infusion therapy if:
    - Your prescription drug is on our plan's formulary, or a formulary exception has been granted for your prescription drug.
    - Your prescription drug is not otherwise covered under our plan's medical benefit or Medi-Cal RX.
    - Our plan has approved your prescription for home infusion therapy.
    - Your prescription is written by an authorized prescriber
- 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're a resident of a long-term care facility, we 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 difficulty accessing your drug benefits in a long-term care facility, 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 dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To find a specialized pharmacy, 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 our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition

Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 100-day supply.

Filling prescriptions by mail

To get information about filling your prescriptions by mail or to get order forms and information about filling your prescriptions by mail, call our mail-order Member Services at 1-833-203-1735 TTY users should call 711. Hours are 24 hours a day, 7 days a week. Our Interactive Voice Response (IVR) Service is available 24 hours a day, seven days a week.

Usually a mail-order pharmacy order will be delivered to you in no more than 14 days. Make sure you have at least one 14-day supply of medication on hand. If you do not have enough, ask your doctor to give you a second prescription for a 30-day supply, and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call the mail-order pharmacy at the phone number provided in the Provider/Pharmacy Directory

Mail-order processes

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 automatically fills and delivers new prescriptions it gets from you.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling the Member Service phone number on your membership card.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel 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.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling the Member Service phone number on your membership card

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

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by providing consent on your first new home delivery prescription, sent in by your physician.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by calling Member Services,

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling Member Services.

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 start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts 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, contact your pharmacy 30 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our auto refill program that automatically prepares mail-order refills, contact us by calling Member Services.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping.

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.

Network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-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 our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't 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 pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- You are traveling within the United States and its territories and become ill or lose or run out of your prescription drugs.
- You are traveling within the United States and its territories, and the prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug that is not regularly stocked at an accessible network retail pharmacy. (For example, an orphan drug or other specialty pharmaceutical.

In these cases, we recommend you check with Member Services first to find out if there's a network pharmacy nearby.

A9. Paying you back for a prescription

Anthem MediBlue Full Dual Advantage is unable to reimburse you for Medi-Cal covered prescriptions.

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

If you pay the full cost for your prescription that may be covered by Medi-Cal Rx, you may be able to be reimbursed by the pharmacy once Medi-Cal Rx pays for the prescription. Alternatively, you may ask Medi-Cal Rx to pay you back by submitting the "Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)" claim. More information can be found on the Medi-Cal Rx website: medi-calrx.dhcs.ca.gov/home/.

To learn more about this, refer to **Chapter 7** of your *Member Handbook*.

B. Our plan's Drug List

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

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare.

Most of the prescription drugs you get from a pharmacy are covered by your plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Generally, generic drugs work just as well as brand-name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products as a supplemental benefit.

Some OTC drugs cost less than prescription drugs and work just as well. This supplement benefit is detailed in the medical benefits chart in Chapter 4 of this Member Handbook.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

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

- Drugs that are **not** covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information

B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List. If a drug was prescribed that is not on our Drug List, your prescription drug needs will always be evaluated under our plan's coverage policies, as well as Medicare coverage rules.

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D) cannot pay for a drug that Medicare Part A or Part B already covers. Our plan covers drugs covered under Medicare Part A or Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medi-Cal cannot cover the types of drugs listed below.

- 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® . (The plan offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan through enhanced drug coverage, such as the erectile dysfunction drug Sildenafil, four tablets per month.)

- Outpatient drugs made by a company that says you must have tests or services done only by them

B4. Drug List tiers

Every drug on our Drug List is in one of 5 tiers. A tier is a group of drugs of generally the same type (for example, brand name and generic)

- Tier 1 includes preferred generic drugs.
- Tier 2 includes generic drugs.
- Tier 3 includes preferred brand drugs.
- Tier 4 includes nonpreferred drugs.
- Tier 5 includes specialty drugs.

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

Chapter 6 of your *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, 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 works 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 must 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, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

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

Generally, a generic drug works the same as a brand name drug and usually costs less. If there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug won't work for you ***or*** wrote "No substitutions" on your prescription for a brand name drug ***or*** told us the medical reason that the generic drug or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that 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, then we 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 our Drug List. For the most up-to-date information, call Member Services or check our website at shop.anthem.com/medicare/ca. If you disagree with our coverage or exception request decision, you may request an appeal. For more information about this, refer to section E in Chapter 9.

D. Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.

- Our plan covers the drug, but there are special rules or limits on coverage for the drug. As explained in the section above some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or 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've 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:
    - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. 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 cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
        - This temporary supply is for up to 30 days.

- If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. 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 our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 34-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
  - To ask for a temporary supply of a drug, call Member Services.

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

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- 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 that is not on our Drug List or 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 take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We 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** of your *Member Handbook*.

If you need help asking for an exception, contact Member Services. If you disagree with our coverage or exception request decision, you may request an appeal (For more information about this, refer to section E in Chapter 9.).

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that 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** unless:

- A new, cheaper drug comes on the market that works as well as a drug on our 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 our Drug List changes, you can always:

- Check our current Drug List online at <shop.anthem.com/medicare/ca> **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List 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 our 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 stays the same.

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 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 send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Member 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 take it off our Drug List. If you are taking the drug, we tell you.

We may make other changes that affect the drugs you take.

We tell you in advance about these other changes to our 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 our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

    If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change. − You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 8.
- We add a generic drug **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:

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

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

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Member Handbook*.

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 do not remove or change coverage of that drug **during the rest of the year**.

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

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

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

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing home, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live 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, contact Member Services.

F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not

related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, 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 covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Member Handbook* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you 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 take 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 work with your provider to correct the problem.

G2. Programs to help you manage your drugs

You may take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely. In such cases, 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 of 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

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take and why you take them.
- 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.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- 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 who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

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

G3. Drug management program for safe use of opioid medications

Our plan 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 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 a certain pharmacy and/or from a certain doctor.
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains 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 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 make an appeal. If you make an appeal, we will review your case and give you a written decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

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 Rx, **and**
- Drugs and items covered by our plan as additional benefits.

Because you are eligible for Medi-Cal, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.”

> **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 your *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 5 tiers each drug is in
        - If there are any limits on the drugs

- If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at shop.anthem.com/medicare/ca.
- Coverage for non-prescribed over-the-counter (OTC) medications is offered as a supplemental benefit. Please refer to chapter 4 Medical Benefits Chart for details.
- Most of the prescription drugs you get from a pharmacy are covered by Anthem MediBlue Full Dual Advantage (HMO D-SNP). Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx."

- **Chapter 5** of your *Member Handbook*.
  - It 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 our plan does not cover.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* more information about network pharmacies.

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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. Since all members pay $0 for covered Part D prescriptions, this will not apply to you.
- 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 *Part D Explanation of Benefits*. We call it the Part D EOB for short. The Part D EOB has more information about the drugs you take such as increases in total drug cost.

The Part D 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 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.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs. This includes prescription filled through Medi-Cal Rx.
- Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 1-800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.
- To find out which drugs our plan covers, refer to our 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 plan ID card.**

   Show your Anthem MediBlue Full Dull Advantage (HMO D-SNP) ID card every time you get a prescription filled. This helps 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 paid for. You can ask us to pay you back for 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

   For more information about asking us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.

3. **Send us information about 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.

4. **Check the EOBs we send you.**

   When you get a Part D EOB in the mail, make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, call Member

Services. Keep these Part D EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules.

C1. Our tiers

Tiers are groups of drugs on our plan's Drug List. Every drug on our Drug List is in one of <5> tiers. **You have no copays for prescription** on our Drug List. To find the tiers for your drugs, refer to our Drug List.

- Tier 1 includes preferred generic drugs.
- Tier 2 includes generic drugs.
- Tier 3 includes preferred brand drugs.
- Tier 4 includes nonpreferred drugs.
- Tier 5 includes specialty drugs.

C2. Your pharmacy choices

How much you pay for a drug *does not* depend 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** of your *Member Handbook* to find out when we do that. Refer to Chapter 9 to learn about how to file an appeal if you are told a drug will not be covered.

To learn more about these pharmacy choices, refer to **Chapter 5** of your *Member Handbook* and our *Provider and Pharmacy Directory*.

C3. 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 for drugs in Tiers 2-5 and up to a 100-day supply for drugs in Tier 1. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our *Provider and Pharmacy Directory*.

C4. What you pay

You pay $0 for all covered prescriptions in all tiers.

Coverage for non-prescribed OTC medication is offered as a supplemental benefit and can be found in Chapter 4 Medical Benefits Chart.

Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

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

You pay $0 for all covered prescriptions in all tiers through retail pharmacies, mail order pharmacies and long-term care pharmacies.

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

D. Vaccinations

Important Message About What You Pay for Vaccines – Our plan covers most Medicare Part D vaccines at no cost to you. 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.

D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination

Chapter 7: Asking us to pay a bill you got 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 your *Member Handbook*.

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A. Asking us to pay for your services or drugs

Our network providers must bill the health plan for your covered services and drugs after you get them. A network provider works with the health plan. **If you get a bill for health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services if you have any questions. If you get a bill and you don't 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. Refer to Chapter 3, section D4, page 43.**

   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 don't 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 already paid for the service, we will pay you back.
   - Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

2. **When a network provider sends you a bill**

   Network providers must always bill us. Show your plan ID card when you get any services or prescriptions. Improper or inappropriate billing occurs when a provider

(such as a doctor or hospital) bills you more than our cost sharing amount for services. **Call Member Services if you get any bills. Do not pay the bill.**

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back*:* for your covered services*.*

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.

4. When you pay the full prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back.

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

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*)*.*

  - 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** of your *Member Handbook*).

- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's 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 give us all the information we need to make a decision, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website shop.anthem.com/medicare/ca, or you can call Member Services and ask for the form.

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

Anthem Blue Cross
P.O. Box 366
Artesia, CA 90702-0366

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we pay the provider directly.

Chapter 3 of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to **Chapter 9 Section E.**

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 don't agree with the amount we pay.

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Member Handbook*:

- To make an appeal about getting paid back for a health care service, refer to **Section F.**
- To make an appeal about getting paid back for a drug, refer to **Section G.**

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 your *Member Handbook*.

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A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our 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 free interpreter services available to 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. To obtain materials in one of these alternative formats, please call **1-833-707-3129** or write to Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
    - 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. You can call Member Services and ask to have materials sent to you in Spanish, Chinese, Armenian, Korean, Russian, Vietnamese, Farsi, Tagalog, Khmer or Arabic.
    - You can get this document for free in other languages and formats, such as large print, braille or audio. Call Member Services at the number listed on the bottom of this page. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at shop.anthem.com/medicare/ca.

If you have 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.
- U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.

A. Su derecho a recibir servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que se le proporcionen todos los servicios de una forma culturalmente adecuada y accesible. También debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda entender. Debemos brindarle información sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener información que pueda entender, llame a Servicios para Miembros. Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder las preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del español y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame al **1-833-707-3129** o escriba a Anthem MediBlue Full Dual Advantage (HMO DSNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
    - Para obtener información que pueda entender, llame a Servicios para Miembros. Nuestro plan cuenta con personas que pueden responder las preguntas en diferentes idiomas. También puede brindarle materiales en otros idiomas, además del español, y en formatos como letra grande, braille o audio. Puede llamar a Servicios para Miembros y pedir que le envíen los materiales en español, chino, armenio, coreano, ruso, vietnamita, farsi, tagalo, khmer o árabe.
    - Puede recibir este documento de forma gratuita en otros idiomas y formatos, como en letra grande, braille o audio. Llame a Servicios para Miembros al número que figura en la parte inferior de esta página. Cuando llame, indique si se trata de un pedido regular. Eso quiere decir que, todos los años, enviaremos los mismos documentos en el formato e idioma solicitados. Puede llamarnos para cambiar o cancelar el pedido regular. También puede encontrar los documentos en línea, en shop.anthem.com/medicare/ca.

Si tiene dificultades para recibir información de nuestro plan debido a limitaciones de idioma o a una discapacidad, y desea presentar una queja, puede comunicarse 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.

- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos (HHS) de los Estados Unidos al 1800368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.
- La Oficina de Derechos Civiles al 916-440-7370. Los usuarios de TTY deben llamar al 711.

A. 您以滿足您需求的方式獲得服務和資訊的權利

我們必須確保以符合您的文化習慣和無障礙的方式向您提供所有服務。我們還必須以您能夠瞭解的方式告知您本計劃的福利以及您的權利。在您加入本計畫期間，我們必須每年均將您的權利告知您。

- **如欲以您能**夠了解的方式取得資訊，請致電會員服務部。我們的計劃提供免費口譯服務，可以用不同語言回答問題。
- **本計畫也給予您英語以外的語言和大型字體印刷、點字或音訊格式的資料。要獲得其中一種替代格式的材料，請致電 1-833-707-3129 或寫信至 Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007。**
  - **如欲以您能**夠了解的方式取得資訊，請致電會員服務部。我們的計劃有可以用不同語言回答問題的人員。我們的計劃也給予您英語以外的語言和大字型印刷、點字或音訊格式的資料。 **您可致電會員服務部，要求向您傳送採用西班牙文、中文、亞美尼亞文、韓文、俄文、越南文、波斯文、菲律賓文、高棉文或阿拉伯文的材料。**
  - **您可以免費取得此檔案的其他語言和格式版本，例如大號字體印刷版、盲文或音訊。致電會員服務部，電話號碼見本頁面底部。致電時，請告知我們您是否希望這是一項常規訂單。這意味著我們每年都會以您要求的格式和語言發送相同的文件。您也可以致電我們更改或取消長期訂單。您也可以從** shop.anthem.com/medicare/ca **在線上尋找您的文件。**

如果您因為語言問題或殘疾而無法從我們的計劃中獲得資訊，並且您想提出投訴，請致電：

- Medicare，電話是 1-800-MEDICARE (1-800-633-4227)。**您可每週7天，每天24小時撥打該電話。聽障專綫使用者可以致電**1-877-486-2048。
- **美國衛生與大眾服務部民權辦公室，電話是** 1800368-1019。聽障專綫使用者可以致電 1-800-537-7697。
- Medi-Cal **民權辦公室，電話是** 916-440-7370。聽障專綫使用者可以致電711。

A. Quyền được nhận các dịch vụ và thông tin theo cách phù hợp với nhu cầu của quý vị

Chúng tôi phải đảm bảo **tất cả** các dịch vụ được cung cấp cho quý vị theo cách phù hợp với văn hóa và dễ tiếp cận. Chúng tôi cũng phải cho quý vị biết các quyền lợi của chương trình của

chúng tôi và quyền của quý vị theo cách mà quý vị có thể hiểu được. Chúng tôi phải thông báo về các quyền của quý vị mỗi năm khi quý vị tham gia chương trình của chúng tôi.

- Để được nhận thông tin theo cách mà quý vị có thể hiểu được, xin gọi cho Ban Dịch vụ Thành viên. Chương trình của chúng tôi có các dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi bằng các ngôn ngữ khác nhau.
- Chương trình chúng tôi cũng có thể cung cấp cho quý vị các tài liệu bằng những ngôn ngữ khác ngoài Tiếng Anh ở các dạng thức như chữ in lớn, chữ nổi Braille, hoặc âm thanh. Để nhận tài liệu ở một trong các định dạng thay thế này, vui lòng gọi **1-833-707-3129** hoặc viết thư cho Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
    - Để được nhận thông tin theo cách mà quý vị có thể hiểu được, xin gọi cho Ban Dịch vụ Thành viên. Chương trình của chúng tôi có những người có thể trả lời các câu hỏi bằng các ngôn ngữ khác nhau. Chương trình chúng tôi cũng có thể cung cấp cho quý vị các tài liệu bằng những ngôn ngữ khác ngoài Tiếng Anh ở các dạng thức như chữ in lớn, chữ nổi Braille, hoặc âm thanh. Quý vị có thể gọi Ban Dịch vụ Thành viên và yêu cầu gửi các tài liệu cho quý vị bằng tiếng Tây Ban Nha, tiếng Trung, tiếng Armenia, tiếng Hàn, tiếng Nga, tiếng Việt, tiếng Ba Tư, tiếng Tagalog, tiếng Khmer hay tiếng Ả-rập.
    - Quý vị có thể yêu cầu cung cấp miễn phí tài liệu này ở các ngôn ngữ và dạng thức khác, như chữ in lớn, chữ nổi braille hoặc âm thanh. Gọi Ban Dịch vụ Thành viên theo số được ghi ở cuối trang này. Khi gọi điện, hãy cho chúng tôi biết nếu quý vị muốn yêu cầu lệnh thường trực. Điều này có nghĩa là chúng tôi sẽ gửi các tài liệu tương tự theo định dạng và ngôn ngữ yêu cầu hàng năm. Quý vị cũng có thể gọi cho chúng tôi để thay đổi hoặc hủy bỏ yêu cầu lệnh thường trực. Quý vị cũng có thể tìm thấy các tài liệu của mình tại shop.anthem.com/medicare/ca.

Nếu quý vị gặp khó khăn khi tiếp nhận thông tin từ chương trình chúng tôi do bất đồng ngôn ngữ hay khuyết tật và quý vị muốn khiếu nại, vui lòng gọi:

- Medicare theo số 1-800-MEDICARE (1-800-633-4227). Quý vị có thể gọi đến vào 24 giờ trong ngày, 7 ngày trong tuần. Người dùng TTY xin gọi 1-877-486-2048.
- Sở Y tế và các Dịch vụ Nhân sinhỳ, Văn phòng Quyền Công dân theo số 1800368-1019. Người dùng TTY xin gọi 1-800-537-7697.
- Medi-Cal Văn phòng Quyền Công dân theo số 916-440-7370. Người dùng TTY xin gọi 711.

A. Ang iyong karapatan na makakuha ng mga serbisyo at impormasyon sa paraang nakakatugon sa iyong mga pangangailangan

Dapat naming tiyakin na ang **lahat** ng mga serbisyo ay ibinibigay sa iyo sa isang kultural na kakayahan at naa-access na paraan. Dapat din naming sabihin sa iyo ang tungkol sa mga benepisyo ng aming plano at ang iyong mga karapatan sa paraang mauunawaan mo. Dapat naming sabihin sa iyo ang tungkol sa iyong mga karapatan bawat taon na ikaw ay nasa aming plano.

- Upang makakuha ng impormasyon sa paraang mauunawaan mo, tawagan ang Mga Serbisyo sa Miyembro. Ang aming plano ay may mga libreng serbisyo ng interpreter na magagamit upang sagutin ang mga tanong sa iba't ibang wika.
- Ang aming plano ay maaari ding magbigay sa iyo ng mga materyales sa mga wika maliban sa Ingles at sa mga format tulad ng malaking print, braille, o audio. Upang makakuha ng mga materyales sa isa sa mga alternatibong format na ito, mangyaring tumawag sa **1-833-707-**

3129 o sumulat sa Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.

- Upang makakuha ng impormasyon sa paraang mauunawaan mo, tawagan ang Mga Serbisyo sa Miyembro. Ang aming plano ay may mga taong makakasagot sa mga tanong sa iba't ibang wika. Ang aming plano ay maaari ding magbigay sa iyo ng mga materyal sa mga wika maliban sa Ingles at sa mga format tulad ng malalaking print, braille, o audio. Maaari kang tumawag sa Member Services at humiling na magpadala sa iyo ng mga materyales sa Spanish, Chinese, Armenian, Korean, Russian, Vietnamese, Farsi, Tagalog, Khmer o Arabic.
- Makukuha mo ang dokumentong ito nang libre sa iba pang wika at format tulad ng malalaking letra, braille, o audio. Tumawag sa Member Services sa numerong nakalista sa ibaba ng page na ito. Kapag tumatawag, ipaalam sa amin kung gusto mo itong maging standing order. Ibig sabihin, ipapadala namin ang parehong mga dokumento sa iyong hiniling na format at wika bawat taon. Maaari mo rin kaming tawagan para baguhin o kanselahin ang isang standing order. Maaari mo ring mahanap ang iyong mga dokumento online sa shop.anthem.com/medicare/ca.

Kung nahihirapan kang makakuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto mong maghain ng reklamo, tumawag sa:

- Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kang tumawag 24 oras sa isang araw, 7 araw sa isang linggo. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-877-486-2048.
- U.S. Department of Health and Human Services, Office for Civil Rights sa 1800368-1019. Ang mga gumagamit ng TTY ay dapat tumawag sa 18005377697.
- Medi-Cal Office of Civil Rights sa 916-440-7370. Ang mga gumagamit ng TTY ay dapat tumawag sa 711.

A. 가입자는 요구 사항에 맞는 방식으로 서비스와 정보를 얻을 권리를 가집니다.

모든 서비스는 문화적 수준에 부합하고 접근성 있는 방식으로 제공되어야 하며, 가입자가 이해할 수 있는 방법으로 플랜의 혜택 및 가입자 권리를 설명해야 합니다. 또한 가입자가 당사 플랜에 가입한 후 매년 가입자의 권리에 대해 알려야 합니다.

- 가입자가 이해할 수 있는 방식으로 정보를 얻으려면 가입자 서비스부로 전화해 주십시오. 당사 플랜에는 다양한 언어로 질문에 답변해줄 통역사 서비스가 있습니다.
- 또한 대형 활자체, 점자, 오디오와 같은 형식과 영어 이외의 언어로 된 자료를 제공해드릴 수도 있습니다. 이러한 대안적 형식으로 자료를 제공 받으려면 **1833-707-3129**번으로 전화하시거나 Anthem MediBlue Full Dual Advantage (HMO D-SNP)에 P.O. Box 60007, Los Angeles, CA 90060-0007의 주소로 편지를 보내주십시오.
  - 가입자가 이해할 수 있는 방식으로 정보를 얻으려면 가입자 서비스부로 전화해 주십시오. 당사 플랜에는 다양한 언어로 질문에 답변해줄 담당자가 있습니다. 당사 플랜은 대형 활자체,

점자, 오디오와 같은 형식과 영어 이외의 언어로 된 자료를 제공해드릴 수도 있습니다. 가입자 서비스부에 전화하여 스페인어, 중국어, 아르메니아어, 한국어, 러시아어, 베트남어, 페르시아어, 타갈로그어, 크메르어 또는 아랍어로 이러한 자료를 요청할 수 있습니다.

- 본 문서는 대형 활자체, 점자 또는 오디오와 같은 기타 언어 및 형식으로 무료로 제공해 드릴 수 있습니다. 이 페이지 하단에 열거된 번호로 가입자 서비스부에 전화해 주세요. 전화를 거실 때 다른 형식 또는 언어에 대한 귀하의 요청이 향후에도 상시 지시로 적용되기를 원하시는지 알려주세요. 그렇게 원하시면 요청하신 형식과 언어로 매년 동일한 서류를 보내드릴 것입니다. 상시 지시를 변경하거나 취소하려면 저희에게 연락하시면 됩니다. 필요한 서류는 shop.anthem.com/medicare/ca에서 온라인으로도 확인하실 수 있습니다.

언어 문제나 장애로 인해 당사 플랜으로부터 정보를 얻는 데 문제가 있어 불만을 제기하실 경우, 연락하실 수 있는 전화번호는 다음과 같습니다.

- Medicare: 1-800-MEDICARE (1-800-633-4227)번. 주 7일 하루 24시간 언제든 문의하실 수 있습니다. TTY 사용자는 1-877-486-2048번을 이용해 주십시오.
- 미국 보건 복지부, 시민권 사무소: 1800368-1019번. TTY 사용자는 1-800-537-7697번을 이용해 주십시오.
- Medi-Cal 시민권 사무소: 916-440-7370번. TTY 사용자는 711번을 이용해 주십시오.

A. Ձեր իրավունքը ստանալու ծառայությունները և տեղեկություններն այնպես, որ բավարարեն ձեր կարիքները

Մենք պետք է ապահովենք, որ **բոլոր** ծառայությունները ձեզ տրամադրվեն մշակութային առումով գրագետ և մատչելի ձևով: Մենք պետք է նաև ձեզ տեղեկացնենք մեր ծրագրի նպաստների և ձեր իրավունքների մասին այնպես, որ դուք կարողանաք հասկանալ: Մենք պետք է պատմենք ձեզ ձեր իրավունքների մասին յուրաքանչյուր տարի, երբ դուք գտնվում եք մեր ծրագրում:

- Որպեսզի ստանաք տեղեկություն ձեզ համար ընկալելի ձևով, զանգահարեք Անդամների սպասարկման կենտրոն: Մեր ծրագիրն ունի անվճար թարգմանչական ծառայություններ տարբեր լեզուներով հարցերին պատասխանելու համար:
- Մեր ծրագիրը կարող է նյութերը տրամադրել նաև այլ լեզուներով (բացի անգլերենից) և այնպիսի ձևաչափերով, ինչպիսիք են՝ մեծ չափերով տպագիր, բրայլյան կամ աուդիո տարբերակները: Այս այլընտրանքային ձևաչափերից որևէ մեկով նյութեր ձեռք բերելու համար զանգահարեք **1-833-707-3129** կամ գրեք Anthem MediBlue Full Dual Advantage-ին (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007:
    - Որպեսզի ստանաք տեղեկություն ձեզ համար ընկալելի ձևով, զանգահարեք Անդամների սպասարկման կենտրոն: Մեր ծրագրում կան մարդիկ, ովքեր կարող են պատասխանել հարցերին տարբեր լեզուներով: Մեր ծրագիրը կարող է նաև ձեզ նյութեր տրամադրել անգլերենից բացի այլ լեզուներով և ձևաչափերով, ինչպիսիք են խոշոր տպագիր, բրայլյան կամ աուդիո տարբերակները: Կարող եք զանգահարել Անդամների սպասարկման կենտրոն և խնդրել, որպեսզի այս տեղեկատվությունը ձեզ

ուղարկվի իսպաներեն, չինարեն, հայերեն, կորեերեն, ռուսերեն, վիետնամերեն, պարսկերեն, թագալերեն, քմերեն կամ արաբերեն լեզուներով:
- Դուք կարող եք անվճար ստանալ այս փաստաթուղթն այլ լեզուներով և ձևաչափերով, ինչպես օրինակ՝ խոշոր տառատեսակով տպագրությունը, բրայլյան ձևաչափը կամ ձայնագրությունը: Զանգահարեք Անդամների սպասարկման կենտրոն այս էջի ներքևում նշված հեռախոսահամարով: Զանգահարելիս տեղեկացրեք մեզ՝ արդյոք ցանկանում եք, որ դա մշտական պահանջ լինի: Սա նշանակում է, որ մենք ամեն տարի նույն փաստաթղթերը կուղարկենք ձեր պահանջած ձևաչափով և լեզվով: Կարող եք նաև զանգահարել մեզ՝ մշտական պահանջը փոխելու կամ չեղարկելու համար: Դուք կարող եք նաև գտնել ձեր փաստաթղթերն առցանց՝ shop.anthem.com/medicare/ca:

Եթե լեզվական խնդիրներ կամ հաշմանդամության պատճառով խնդիրներ ունեք մեր ծրագրից տեղեկություններ ստանալու հետ, և ցանկանում եք բողոք ներկայացնել, զանգահարեք.
- Medicare 1-800-MEDICARE (1-800-633-4227): Կարող եք զանգահարել օրը 24 ժամ, շաբաթը 7 օր: TTY-ից օգտվողները պետք է զանգահարեն՝ 1-877-486-2048:
- ԱՄՆ Առողջապահության և մարդկային ծառայությունների վարչության Քաղաքացիական իրավունքների գրասենյակ՝ 1800368-1019: TTY-ից օգտվողները պետք է զանգահարեն՝ 1-800-537-7697:
- Medi-Cal Քաղաքացիական իրավունքների գրասենյակ՝ 916-440-7370: TTY-ից օգտվողները պետք է զանգահարեն՝ 711:

A. حق شما برای دریافت خدمات و اطلاعات به گونه‌ای که پاسخگوی نیازهای شما باشد

باید اطمینان حاصل کنیم که **همه** خدمات به شیوه‌ای متناسب با فرهنگ‌تان و قابل دسترس به شما ارائه می‌شود. همچنین باید درباره مزایای طرح و حقوق شما به نحوی که برای شما قابل درک باشد اطلاع‌رسانی کنیم. باید هر سال که عضو طرح ما هستید، به شما درباره حقوق‌تان اطلاع‌رسانی کنیم.

- برای دریافت اطلاعات به گونه‌ای که برای شما قابل فهم باشد، با مرکز خدمات اعضا تماس بگیرید. در طرح ما مترجمان شفاهی رایگانی هستند که می‌توانند به زبان‌های مختلف به پرسش‌های شما پاسخ دهند.
- طرح ما همچنین می‌تواند اطلاعات مورد نیاز شما را به زبان‌های غیر از انگلیسی و به فرمت‌های گوناگون شامل چاپ درشت، خط بریل، یا فایل صوتی در اختیار شما قرار دهد. برای دریافت مطالب در یکی از این فرمت‌های جایگزین، لطفاً با شماره **1-833-707-3129** تماس بگیرید یا با Anthem MediBlue HMO D (SNP-Full Dual Advantage) مکاتبه کنید. P.O. Box 60007, Los Angeles, CA 90060-0007.
  - برای دریافت اطلاعات به گونه‌ای که برای شما قابل فهم باشد، با مرکز خدمات اعضا تماس بگیرید. طرح ما شامل افرادی است که می‌توانند به زبان‌های مختلف پاسخگوی سؤالات شما باشند. همچنین این طرح می‌تواند اطلاعات مورد نیاز شما را به زبان‌های غیر از انگلیسی و به فرمت‌های گوناگون شامل چاپ درشت، خط بریل، یا فایل صوتی در اختیار شما قرار دهد. می‌توانید با مرکز خدمات اعضا تماس بگیرید و درخواست کنید تا مطالب موجود به زبان‌های اسپانیایی، چینی، ارمنی، کره‌ای، روسی، ویتنامی، فارسی، تاگالوگ، خمر یا عربی برای شما ارسال شوند.
  - می‌توانید این سند را به‌صورت رایگان در زبان‌ها و فرمت‌های دیگر مانند چاپ درشت، خط بریل یا فرمت صوتی دریافت کنید. با مرکز خدمات اعضا به شماره مندرج در پایین این صفحه تماس بگیرید. اگر می‌خواهید این درخواست را به‌عنوان درخواست دائمی ثبت کنید، هنگام تماس به ما اطلاع دهید. این بدین معنی است که ما هر سال این اسناد را به فرمت و زبان درخواستی شما ارسال می‌کنیم. همچنین می‌توانید برای تغییر یا لغو درخواست دائمی خود با ما تماس بگیرید. می‌توانید مدارک خود را به‌صورت آنلاین در آدرس shop.anthem.com/medicare/ca نیز پیدا کنید.

اگر دریافت اطلاعات از برنامه ما به دلیل مشکلات زبانی یا ناتوانی برای شما دشوار است و می‌خواهید شکایت ارائه دهید، با شماره زیر تماس بگیرید:

- Medicare به شماره MEDICARE (1-800-633-4227)-800-1. می توانید در 24 ساعت شبانه‌روز و 7 روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند.
- دفتر حقوق مدنی در وزارت بهداشت و خدمات انسانی امریکا با شماره تلفن 1800368-1019. کاربران TTY باید با شماره 1-800-537-7697 تماس بگیرند.
- دفتر حقوق مدنی Medi-Cal به شماره 916-440-7370. کاربران TTY باید با شماره 711 تماس بگیرند.

دارید برای کمک گرفتن با مرکز خدمات اعضا تماس بگیرید.

A. Вы имеете право получать необходимые вам помощь и информацию

Мы должны следить за тем, чтобы **все** обслуживание было доступным и чтобы вы получали его с учетом ваших культурных особенностей. О покрываемом планом обслуживании и о ваших правах мы должны сообщать в понятной вам форме. Пока вы остаетесь участником нашего плана, мы должны каждый год сообщать вам о ваших правах.

- Для того чтобы получить информацию в удобной для вас форме, позвоните в наш отдел обслуживания. У нас есть устные переводчики, которые на различных языках отвечают на вопросы участников плана.
- Кроме того, вы можете получить материалы нашего плана в переводе на другие языки или в других формах, например в виде аудиозаписи или напечатанными крупным шрифтом или шрифтом Брайля. Для того чтобы получать материалы плана в одной из альтернативных форм, позвоните по номеру **1-833-707-3129** или напишите по следующему адресу: Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007 .
  - Для того чтобы получить информацию в удобной для вас форме, позвоните в наш отдел обслуживания. У нас есть люди, которые на различных языках отвечают на вопросы участников плана. Кроме того, вы можете получить материалы нашего плана в переводе на другие языки или в других формах, например в виде аудиозаписи или напечатанными крупным шрифтом или шрифтом Брайля. Вы можете позвонить в отдел обслуживания и попросить, чтобы материалы плана вам присылали на испанском, китайском, армянском, русском, вьетнамском, тагальском, кхмерском или арабском языке или на фарси.
  - Этот документ можно бесплатно получить на других языках и в других формах, например напечатанным крупным шрифтом, шрифтом Брайля или в виде аудиозаписи. Позвоните в отдел обслуживания по номеру, указанному в нижней части страницы. Во время разговора снашим сотрудником попросите считать ваше распоряжение долгосрочным. В этом случае мы будем ежегодно присылать вам документы на выбранном языке и в выбранной форме. Вы всегда можете нам позвонить, чтобы изменить или отменить ваши долгосрочные распоряжения. Кроме того, необходимые вам документы есть на сайте shop.anthem.com/medicare/ca.

Если из-за инвалидности или недостаточного знания английского языка вам трудно разбираться в информации, которую мы вам сообщаем, то можете подать жалобу:

- В программу Medicare по номеру 1-800-MEDICARE (1-800-633-4227). Звонить можно круглосуточно и в любой день недели. Пользователям TTY следует звонить по номеру 1-877-486-2048.

- В Управление по вопросам гражданских прав при Департаменте здравоохранения и социальных служб по номеру 1800368-1019. Пользователям TTY следует звонить по номеру 1-800-537-7697.
- В отдел гражданских прав при программе Medi-Cal по номеру 916-440-7370. Пользователям TTY следует звонить по номеру 711.

A. حقك في الحصول على الخدمات والمعلومات بطريقة تلبي احتياجاتك

يجب أن نحرص على أن تكون **جميع** الخدمات التي نقدمها إليك مناسبة لثقافتك ويمكن الوصول إليها بسهولة. يجب أن نخبرك أيضاً عن مزايا خطتنا وحقوقك بطريقة يمكنك فهمها. ويجب أن نخبرك عن حقوقك سنوياً طالما أنك مسجَّل في خطتنا.

- للحصول على المعلومات بالطريقة التي يمكنك فهمها، اتصل بخدمات الأعضاء. لدينا في خطتنا خدمات الترجمة الفورية التي يمكنك الاستعانة بها للحصول على إجابة عن الأسئلة بلغات مختلفة.
- يمكن لخطتنا توفير المواد لك بلغات أخرى غير اللغة الإنجليزية، وبتنسيقات مثل الطباعة بأحرف كبيرة أو طريقة برايل أو مسجلة صوتياً. للحصول على المستندات بتنسيق مختلف من هذه التنسيقات، يُرجى الاتصال بالرقم **83370731291** أو إرسال رسالة كتابية إلى Anthem MediBlue Full Dual Advantage (HMO D-SNP) . P.O. Box 60007, Los Angeles, CA 90060-0007
  - للحصول على المعلومات بالطريقة التي يمكنك فهمها، اتصل بخدمات الأعضاء. هناك أشخاص يعملون في خطتنا بإمكانهم الإجابة عن أسئلتك بلغات مختلفة. يمكن لخطتنا توفير المواد لك بلغات أخرى غير اللغة الإنجليزية، وبتنسيقات مثل الطباعة بأحرف كبيرة أو طريقة برايل أو مسجلة صوتياً. يمكنك الاتصال بخدمات الأعضاء وطلب إرسال المواد لك باللغة الإسبانية أو الصينية أو الأرمينية أو الكورية أو الروسية أو الفيتنامية أو الفارسية أو التاغالوغية أو الخميرية أو العربية.
  - يمكنك الحصول على هذا المستند مجاناً بلغات وتنسيقات أخرى كأن تكون مطبوعةً بأحرف كبيرة أو بطريقة برايل أو مسجلة صوتياً. اتصل بخدمات الأعضاء على الرقم المدرج في الجزء السفلي من هذه الصفحة. عند الاتصال، أخبرنا إذا كنت تريد أن يكون ذلك طلباً ثابتاً. ويعني ذلك أننا سنرسل نفس المستندات بالتنسيق واللغة المطلوبين من جانبك كل عام. يمكنك أيضاً الاتصال بنا لتغيير أو إلغاء طلب ثابت. يمكنك أيضاً العثور على مستنداتك عبر الإنترنت على الموقع الإلكتروني shop.anthem.com/medicare/ca.

إذا واجهت مشكلة في الحصول على معلومات من خطتنا بسبب مشكلات لغوية أو إعاقة وتريد تقديم شكوى، فاتصل على:

- Medicare على الرقم 1-800-MEDICARE (1-800-633-4227). يمكنك الاتصال على مدار الساعة وطوال أيام الأسبوع. ويجب على مستخدمي TTY الاتصال على الرقم 1-877-486-2048.
- مكتب الحقوق المدنية التابع لوزارة الصحة والخدمات الإنسانية الأمريكية على الرقم 1-800-368-1019. ويجب على مستخدمي TTY الاتصال على الرقم 1-800-537-7697.
- مكتب Medi-Cal للحقوق المدنية على الرقم 916-440-7370 ويجب على مستخدمي TTY الاتصال على الرقم 711.

A. អ្នកមានសិទ្ធិទទួលបានសេវាកម្ម និងព័ត៌មានតាមមធ្យោបាយណាមួយដែលអ្នកពេញចិត្ត

យើងក៏ត្រូវតែធានាថាសេវាកម្ម**ទាំងអស់**ត្រូវបានផ្តល់ជូនអ្នកទៅតាមលក្ខណៈវប្បធម៌ និងលក្ខណៈដែលអ្នកអាចប្រើប្រាស់បាន។ យើងក៏ត្រូវប្រាប់អ្នកអំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកតាមវិធីដែលអ្នកអាចយល់បាន។ យើងត្រូវប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នករៀងរាល់ឆ្នាំដែលអ្នកស្ថិតនៅក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មានក្នុងទម្រង់ដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅផ្នែកសេវាសមាជិក។ គម្រោងរបស់យើងមានសេវាអ្នកបកប្រែផ្ទាល់មាត់តាមតិតម្លៃដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។

- គម្រោងរបស់យើងអាចផ្តល់ជូនអ្នកនូវសម្ភារៈ ជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស និងជាទ្រង់ទ្រាយផ្សេងទៀតដូចជាអក្សរបោះពុម្ពធំៗ អក្សរសម្រាប់ជនពិការភ្នែក ឬ ជាសំឡេង។ ដើម្បីទទួលបានឯកសារក្នុងទម្រង់ផ្សេងទៀត សូមហៅទូរសព្ទមកលេខ **1-833-707-3129** ឬសរសេរសារទៅ Anthem MediBlue Full Dual Advantage (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007។
  - ដើម្បីទទួលបានព័ត៌មានក្នុងទម្រង់ដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅផ្នែកសេវាសមាជិក។ គម្រោងរបស់យើងមានអ្នកដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។ គម្រោងរបស់យើងអាចផ្តល់ជូនអ្នកនូវសម្ភារឯកសារជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស និងជាទ្រង់ទ្រាយផ្សេងទៀតដូចជាអក្សរបោះពុម្ពធំៗ អក្សរសម្រាប់ជនពិ ការភ្នែក ឬជាសំឡេង។ អ្នកអាចទូរសព្ទទៅផ្នែកសេវាសមាជិកហើយសុំឱ្យគេផ្ញើឯកសារទៅអ្នកជាភាសាអេស្ប៉ាញ ចិន អាមេនី កូរ៉េ រុស្ស៊ី វៀតណាម ហ្វាស៊ី តាកាឡុក ខ្មែរ ឬអារ៉ាប់។
  - អ្នកអាចទទួលបានឯកសារនេះដោយឥតគិតថ្លៃតាមទម្រង់ និងភាសាផ្សេងៗដូចជាការបោះពុម្ពអក្សរធំៗ អក្សរសម្រាប់មនុស្សពិការភ្នែក ឬជាសំឡេង។ ទូរសព្ទទៅកាន់សេវាសមាជិកតាមលេខទូរសព្ទដែលរាយនៅផ្នែកខាងក្រោមនៃទំព័រ។ នៅពេលហៅទូរសព្ទ សូមប្រាប់យើងប្រសិនបើអ្នកចង់ដាក់វាជាសំណើជាប្រចាំ។ មានន័យថាយើងនឹងផ្ញើឯកសារដូចគ្នាទៅតាមទម្រង់ និងភាសាដែលអ្នកបា នស្នើសុំជារៀងរាល់ឆ្នាំ។ អ្នកក៏អាចហៅទូរសព្ទមកយើងខ្ញុំដើម្បីផ្លាស់ប្តូរ ឬបញ្ឈប់សំណើរជាប្រចាំផងដែរ។ អ្នកក៏អាចស្វែងរកឯកសាររបស់អ្នកលើបណ្តាញអ៊ីនធឺណិតបានផងដែរតាម shop.anthem.com/medicare/ca។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹង សូមហៅទូរសព្ទមកលេខ៖

- Medicare តាម 1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចហៅបាន 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកប្រើប្រាស់ TTY គួរតែទូរសព្ទទៅកាន់លេខ 1-877-486-2048។
- នាយកដ្ឋានសុខភាព និងសេវាមនុស្សសាស្ត្រ ការិយាល័យសម្រាប់សិទ្ធិស៊ីវិលតាមលេខ 1800368-1019 ។ អ្នកប្រើប្រាស់ TTY គួរតែទូរសព្ទទៅកាន់លេខ 1-800-537-7697។
- ការិយាល័យសិទ្ធិស៊ីវិលរបស់ Medi-Cal តាមលេខ 916-440-7370។ អ្នកប្រើប្រាស់ TTY គួរតែទូរសព្ទទៅកាន់លេខ 711។

B. Our responsibility for your timely access to covered services and drugs

You have rights 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** of your *Member Handbook*.

  - 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 a provider 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 service from specialists.
  - If you can't get services within a reasonable amount of time, we must 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** of your *Member Handbook*.
- 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** of your *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

Chapter 9 of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't 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 information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to your information and to control how your PHI is used. We give you a written notice that tells you about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

Members who may consent to receive sensitive services are not required to obtain any other member's authorization to receive sensitive services or to submit a claim for sensitive services. Anthem MediBlue Full Dual Advantage (HMO D-SNP) will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Anthem MediBlue Full Dual Advantage (HMO D-SNP) will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Anthem MediBlue Full Dual Advantage (HMO D-SNP) will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal and state laws.

C2. Your 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.

- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.

- You have the right to know if and how we shared your PHI with others.

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

Anthem MediBlue Full Dual Advantage (HMO D-SNP)

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in June 2022.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Centers for Medicare & Medicaid Services after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**

  - To help doctors, hospitals and others get you the care you need
- **For payment, healthcare operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them

To find ways to make our programs better, and to support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations and treatment. If you don't want this, please visit shop.anthem.com/medicare/ca for more information.

- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health**

clinic.

- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-833-707-3129.** If you're deaf or hard of hearing, call TTY: **711**.

What if you have a complaint?

We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
90 Seventh St., Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-415-437-8329
or
Privacy Officer c/o Office of HIPAA Compliance
Department of Health Care Services (DHCS)
P.O. Box 997413, MS 4722
Sacramento, CA 95899-7413
Email: privacyofficer@dhcs.ca.gov
Phone: 1-916-445-4646
Fax: 1-916-440-7680
or
Information Security Officer
DHCS Information Security Office
P.O. Box 997413, MS 6400
Sacramento, CA 95899-7413
Email: iso@dhcs.ca.gov
Phone: ITSD Help Desk
1-916-440-7000 or 1-800-579-0874
Fax: 1-916-440-5537

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the Web at shop.anthem.com/medicare/ca/.

Race, ethnicity, language, sexual orientation and gender identity
We get race, ethnicity, language, sexual orientation and gender identity information about you from the state Medicaid agency and the Centers for Medicare & Medicaid Services. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need
- Create programs to improve health outcomes
- Create and send health education information
- Let doctors know about your language needs

- Provide interpretation and translation services

We do **not** use this information to:
- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Share with unapproved users

Your personal information
We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services at **1-833-707-3129** (TTY **711**).

Revised June 2022.

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at **1-833-707-3129** (TTY **711**). This is a free service to you. You can call Member Services and ask to have this information sent to you in Spanish, Chinese, Armenian, Korean, Russian, Vietnamese, Farsi, Tagalog, Khmer or Arabic. We can also give you information in large print, braille, data or audio CD.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - 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 (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) 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 (refer to **Chapter 9** of your *Member Handbook*), 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 balance bill or charge you if we pay less than the amount the

provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

F. Your right to leave our 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 another Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another Medicare Advantage plan.
- Refer to **Chapter 10** of your *Member Handbook:*
    - For more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
    - For information about how you will get your Medi-Cal benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

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 different treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you 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 use 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 have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you 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 denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen

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

- Fill out a written form **giving someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you 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 are not required to have an advance directive, but you can. Here's what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make

decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.

- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Anthem MediBlue Full Dual Advantage (D-SNP) will tell you about changes to the state law no later than 90 days after the change.

Having an advance directive is **your** choice. Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with:

Doctor complaint:
Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200 Sacramento, CA 95815
Toll Free: 1-800-633-2322 (TTY: 711)

Hospital complaint:
California Department of Public Health
Consumer Information System
Phone: 1-800-236-9747 (TTY: 711)

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your *Member Handbook* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can 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 plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Member Handbook* – or you want more information about your rights, you can call:

- Member Services at **1-833-707-3129** (TTY: **711**).
- The Health Insurance Counseling and Advocacy Program (HICAP) program at 1-800-434-0222. For more details about HICAP, refer to Chapter 2.
- The Ombuds Program at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of your *Member Handbook*.
- 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 responsibilities as a plan member

As a plan member, 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 our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. 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 and 6** of your *Member Handbook*.

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them 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 take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and with other providers.
- **Tell us about any services you receive outside of our plan.**
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most plan members, Medi-Cal pays for your Part A premium and your Part B premium.
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells you about our service area.

- We can help you find out if you're 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 tell you if we have a plan in your new area.
- Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
- **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.

- **Tell us if you have a new phone number** or a better way 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 said it won't pay for.
- You disagree with a decision your plan 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.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

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 have a problem with your care, you can call the Ombuds Program at 1-888-452-8609 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the 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** of your *Member Handbook*.

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 **1-833-707-3129** (TTY: **711**), Monday through Friday from 8 a.m. to 8 p.m. and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your

health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If 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.

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints;** also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those, too.

B. Where to get help

B1. For more information and help

Sometimes it’s confusing to start or follow the process for dealing with a problem. This can be especially true if you don’t feel well or have limited energy. Other times, you may not have the information you need to take the next step.

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about 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.

Help from the Health Consumer Alliance

You can call the Health Consumer Alliance and speak with an advocate about your health coverage questions. They offer free legal help. The Health Consumer Alliance is not connected with us or with any insurance company or health plan. Their phone number is 1-888-804-3536 and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. 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 users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from Medi-Cal

For more information and help from Medicaid, contact Medi-Cal. Here are two ways to get help from Medi-Cal:

- Call 1-800-541-5555 (TTY: 711), Monday through Friday 8:00 a.m. to 5:00 p.m.
- Visit the Medi-Cal website (www.medi-cal.ca.gov)

Help from the California Department of Health Care Services

The California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman can help. They can help if you have problems joining, changing or leaving a health plan. They can also help if you moved and are having trouble getting your Medi-Cal transferred to your new county. You can call the Ombudsman Monday through Friday, between 8:00 a.m. and 5:00 p.m. at 1-888-452-8609.

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care for free help. The DMHC is responsible for regulating health plans. The DMHC helps people 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.

C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to **all** of your Medicare and Medi-Cal benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps 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 or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** “Coverage decisions and appeals.”	**No.** My problem is not about benefits or coverage. Refer to **Section K**, “How to make a complaint.”

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we

decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your 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 200 for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. An Independent Review Organization that is not connected to us conducts the Level 2 Appeal.

- In some situations, your case is **automatically sent** to the Independent Review Organization for a Level 2 Appeal. If this happens, we tell you.
- In other situations, you **need to ask** for a Level 2 Appeal.
- Refer to **Section F4** for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **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 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.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
    - 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.
    - Ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page 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 shop.anthem.com/medicare/ca. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, “Medical care”
- **Section G**, “Medicare Part D prescription drugs”
- **Section H**, “Asking us to cover a longer hospital stay”
- **Section I**, “Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you’re not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are usually drugs administered by your doctor or health care professional. Different rules may apply to a Part B prescription drug. When they do, we explain how rules for Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care 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 F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

6. You are experiencing delays in care or you cannot find a doctor.

What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** or **Section I** to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-844-469-6831 (TTY: 711).
- Faxing: 1-877-664-1504
- Writing:
  Anthem Blue Cross
  Coverage Determinations
  P.O. Box 60007
  Los Angeles, CA 60060-0007

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a**:**

- Anthem MediBlue Full Dual Advantage (HMO D-SNP) will decide routine pre-approvals within 5 working days, of when Anthem MediBlue Full Dual Advantage (HMO D-SNP) gets the information needed to make a decision, and no later than 14 calendar days after Anthem MediBlue Full Dual Advantage (HMO D-SNP) receives the request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

Fast coverage decision

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

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a

complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast coverage decision if your doctor asks for it.
- 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 making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won't review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn't legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at **1-833-707-3129**.

Ask for a standard appeal or a fast appeal in writing or by calling us at **1-833-707-3129**.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at shop.anthem.com/medicare/ca.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
    - We dismiss your request, and
    - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

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

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.
- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2**.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal **within 10 calendar days** of the date on our letter or by the intended effective date of the action, whichever is later.
    - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
    - You will also get all other services or items (that are not the subject of your appeal) with no changes.
    - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the Independent Review Organization for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say No to part or all of your request**, you have additional appeal rights:**

If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we 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 service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" is the **"Independent Review Entity,"** sometimes called the **"IRE."**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **If the Independent Review Organization says Yes to part or all of a request for a medical item or service,** we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours** or
  - Provide the service within **14 calendar days** after we get the Independent Review Organization's decision for **standard requests** or
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- If the Independent Review Organization says **Yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:

- **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests** or
- **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests.**

- If the Independent Review Organization says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If your case meets the requirements, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2, for a total of five levels.

If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.

An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medi-Cal usually covers

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 195 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. TTY 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. TTY 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 198 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.

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.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for

coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. 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.**

If you get a bill 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. If you do pay the bill, you can get a refund if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay your back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and 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 you (or your provider) the payment for the service or item within 60 calendar days after we get your request.
- 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 won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization 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 to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and **Medi-Cal** usually covers the service or item, you can file a Level 2 Appeal yourself. We do not automatically file a level 2 appeal for you. Refer to **Section F4** for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Part D drug appeals.** We'll say "drug" in the rest of this section Instead of saying "Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain

medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

G1. Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
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 ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4.**	Refer to **Section G4.**	Refer to **Section G4.**	Refer to **Section G5.**

G2. Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List**

   - If we agree to make an exception and cover a drug that is not on our Drug List, you pay $0.
   - You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**

   - Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

G3. Important things to know about asking for an exception

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 asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request. If you ask us for a tiering exception, we generally do **not** approve your exception request unless all alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-833-293-0661, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

> A “fast coverage decision” is called an **“expedited coverage determination.”**

You can get a fast coverage decision if:

- It’s for a drug you didn’t get. You can’t get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn’t meet the requirements for a fast coverage decision, we use the standard deadlines instead.

We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.

You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor’s supporting statement. We give you our answer sooner if your health requires it.
- If we don’t meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor’s supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard** or **fast appeal** by calling **1-833-707-3129**, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information regarding your claim.
- 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you

had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.

If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" is the **"Independent Review Entity,"** sometimes called the **"IRE."**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the Independent Review Organization.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.

If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're 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. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for 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’re being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you’re admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called **“An Important Message from Medicare about Your Rights.”** Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don’t get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. 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 the notice** carefully and ask questions if you don’t understand. The notice 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’re being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.
    - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- 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.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the Quality Improvement Organization is Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Call them at 1-877-588-1123, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-855-887-6668. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization's decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

- 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 F4 on page 197 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you will get another notice that explains why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- 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 191 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

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

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

- We 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 appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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 F4 on page 197 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.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4** .
- 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 F4 on page 197 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 the numbers at the bottom of the page or 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. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

What happens during a fast-track appeal

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123.

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- 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 F4 on page <15> 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.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

> The legal term for “fast review” or “fast appeal” is **“expedited appeal.”**

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- 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 appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don’t need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

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 F4 on page 197 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.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. 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 of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section J3 of this chapter tells more about Levels 3, 4 and 5 of the appeals process.

J3. Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. 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, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.

Complaint	Example
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the Independent Review Organization on time.

There are different kinds of complaints. 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 not affiliated with our plan. If you need help making an internal and/or external complaint, you can call **1-833-707-3129**.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at 1-833-707-3129. 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 make 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.

- Complaints related to Medicare Part D must be made within 60 calendar days after you had the problem you want to complain about.
- There is no filing limit for complaints related to Medicare Part C or about quality of care.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we 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 don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

You do not need to file a complaint with Anthem MediBlue Full Dual Advantage (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Medi-Cal

You can file a complaint with the California Department of health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The 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 TTY number, 1-877-688-9891*. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

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 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

Customer Response Center: 1-800-368-1019 TTY: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act and under other laws that apply to organizations that get Federal funding, and any other rules that apply for any other

reason. You can contact state's ombudsman toll-free at 1-888-452-8609 or TDD/TTY 1-800-735-2929 (California Relay Service), Monday through Friday from 8 a.m. to 5 p.m. You can access the website at http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx.

Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we 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 **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In California, the Quality Improvement Organization is called Livanta. Their phone number is 1-877-588-1123.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our 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 your *Member Handbook*.

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A. When you can end your membership with our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital.

Your membership ends 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 ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

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

- Medicare options in the table in **Section C1**.
- Medi-Cal services in **Section C2**.

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

- Member Services at the numbers at the bottom of the page.
- 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.
- 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/.
- 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.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program, you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

B. How to end your membership in our plan

You have the following options if you want to leave our plan:

- 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 pages 239-241.
- 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.
- Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medi-Cal services

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
Another 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/. **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan may change.

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	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/. **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

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 are automatically disenrolled from our plan when your Original Medicare coverage begins. Your Medi-Cal plan will not change.

C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact 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. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. How to get your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.

- If you are hospitalized on the day that your membership in Anthem MediBlue Full Dual Advantage (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our 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 only for people who qualify for both Medicare and Medi-Cal. The State or the Centers for Medicare & Medicaid Services (CMS) may disenroll you if it is determined that you are not eligible for the program.
- 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, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
    - Refer to **Chapter 4** of your *Member Handbook* for information on getting care through our visitor or traveler benefits when you're away from 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 notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

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 plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **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.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *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 the *Member Handbook*. The main laws that apply are federal and state 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, sex, or sexual orientation. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

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 the Department of Health Care Services, Office for Civil Rights at 1-916-440-7370. TTY users can call 711 (Telecommunications Relay Service).
- Send an email to CivilRights@dhcs.ca.gov.
- Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Complaint forms are available at:

  www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe that you have been discriminated against and want to file a discrimination grievance, contact the Office for Civil Rights. If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation or national origin, you should call the

Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697), or call your local Office for Civil Rights.

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

Complaint forms are available at dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to CivilRights@dhcs.ca.gov

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 must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *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.

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** of your *Member Handbook* 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.

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.”

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* 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 members 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.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* 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 our plan covers.

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 is 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 (known as Medi-Cal).

Department of Managed Health Care (DMHC): The state department in California responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. 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 5 tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medi-Cal. Our plan is a D-SNP.

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 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 or serious impairment to a bodily function. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services 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 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 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’s 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** of your *Member Handbook* 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. All of them work together to provide the care you need.

Health risk assessment: A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't 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 don't 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.
- We are required to 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 our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay 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 make an appeal. 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 decision is 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.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may 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 also helps you make a care plan.

List of Covered Drugs **(Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose 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 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 (NF).

Low-income subsidy (LIS): Refer to "Extra Help."

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

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** of your *Member Handbook* 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.

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: A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA 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 covered by Medicare Part A and Part B.

Medicare-Medi-Cal enrollee: 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 (such as lab tests, surgeries, and doctor visits) and supplies (such as 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, also known as “Medicare Advantage” or “MA” 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. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Part D. Medi-Cal may cover some of these drugs.

Medication Therapy Management: A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

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 in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when 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 our health plan, accept our payment, and do not charge members an extra amount.
- While you’re 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 can’t get their care at home but don’t 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 in **Chapters 2 and 9** of your *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, make a decision about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9** of your *Member Handbook* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- 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 don’t 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. Our plan doesn’t cover most drugs you get from out-of-network pharmacies 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** of your *Member Handbook* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines 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 our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): 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** of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets prior authorization from us.

- Covered services that need our plan's prior authorization are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs 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): 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: Medical devices ordered by your doctor or other health care provider that 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. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we 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 **Chapters 3 and 4** of your *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

Share of cost: The portion of your health care costs that you may have to pay each month before your 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.

Specialized pharmacy: Refer to Chapter 5 of your *Member Handbook* to learn more about specialized pharmacies.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't 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 try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays 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. SSI automatically provides Medi-Cal coverage.

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.

Anthem MediBlue Full Dual Advantage (HMO D-SNP) Member Services

CALL	**1-833-707-3129** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. Monday through Friday from 8 a.m. to 8 p.m.
WRITE	12900 Park Plaza Drive, Suite 150 Mailstop 6150 Cerritos, CA 90703-9329
WEBSITE	shop.anthem.com/medicare/ca

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