



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

January 1 - December 31, 2027

Your Health and Drug Coverage under Anthem Full Dual Advantage Aligned (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, 2027. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *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 Full Dual Advantage Aligned (HMO D-SNP).

This document is available for free in Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian and Vietnamese.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-833-897-1342 (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 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 www.anthem.com/ca.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-833-897-1342. Someone that speaks Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian and Vietnamese can help you. This is a free service.

H4471_27_3021216_0056_R_C
1091341CASENABC_0056

OMB Approval 0938-1444
(Expires: 5/31/2029)



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) Member Services at 1-833-897-1342 (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. **For more information**, visit www.anthem.com/ca.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English

ATTENTION: If you need help in your language, call 1-833-897-1342 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-833-897-1342 (TTY: 711). These services are free of charge.

العربية (Arabic)

تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فاتصل على الرقم 1-833-897-1342 (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأفراد ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والحروف الكبيرة. اتصل على الرقم 1-833-897-1342 (TTY: 711). هذه الخدمات مجانية دون أي تكلفة.

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե ձեր լեզվով օգնության կարիք ունեք, զանգահարեք 1-833-897-1342 (TTY: 711):
Հասանելի են նաև օգնություն և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպիսիք են բրայլյան և խոշոր տառերով փաստաթղթերը:
Զանգահարեք 1-833-897-1342 (TTY: 711): Այս ծառայություններն անվճար են:



កម្ពុជា (Cambodian)

សូមជ្រាប៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរសព្ទទៅលេខ 1-833-897-1342 (TTY: 711)។
ជំនួយនិងសេវាកម្មសម្រាប់ជនដែលមានពិការភាព
ដូចជាឯកសារជាអក្សរស្នាប និងមានពុម្ពអក្សរធំ
ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-833-897-1342
(TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃនោះទេ។

中文 (Chinese)

注意：如果您需要您的语言协助，请致电 1-833-897-1342
(TTY: 711)。我们还可为残障人士提供帮助和服务，例如盲
文和大字体印刷。致电 1-833-897-1342 (TTY: 711)。这类服务
免费。

فارسی (Farsi)

توجه: اگر به کمک به زبان خودتان نیاز دارید، با 1-833-897-1342
(TTY: 711) تماس بگیرید. خدمات و پشتیبانی‌ها برای افراد معلول مانند اسناد با
خط بریل یا چاپ درشت نیز موجود است. با 1-833-897-1342 (TTY: 711)
تماس بگیرید. این خدمات رایگان و بدون هزینه است.

हिन्दी (Hindi)

ध्यान दें: यदि आपको अपनी भाषा में सहायता चाहिए तो कॉल करें
1-833-897-1342 (TTY: 711)। विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट
में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं। कॉल करें
1-833-897-1342 (TTY: 711)। ये सेवाएँ निःशुल्क हैं।



Hmoob (Hmong)

NCO NTSOOV: Yog koj xav tau kev pab ua koj yam lus, hu 1-833-897-1342 (TTY: 711). Muaj cov khoom thiab kev pab cuam rau cov neeg xiam oob qhab siv, xws li muaj ua ntawv xuas thiab ntawv luam loj. Hu 1-833-897-1342 (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語 (Japanese)

注意: 母国語での助けが必要な場合は、1-833-897-1342 (TTY: 711) までご連絡ください。点字や大活字の文書など、障害者の方ための補助やサービスもご利用いただけます。1-833-897-1342 (TTY: 711) までご連絡ください。これらのサービスは無料です。

한국어 (Korean)

주의: 한국어로 도움이 필요하시면, 1-833-897-1342 (TTY: 711)번으로 전화해 주십시오. 점자 및 대형 활자체 문서와 같은 장애인을 위한 지원 및 서비스도 제공됩니다. 1-833-897-1342 (TTY: 711)번으로 전화해 주십시오. 이러한 서비스는 무료입니다.

ພາສາລາວ (Laotian)

ເອົາໃຈໃສ່: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໃຫ້ໂທຫາ 1-833-897-1342 (TTY: 711). ມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການເຊັ່ນ ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ ແລະ ຕົວພິມຂະໜາດໃຫຍ່. ໂທ 1-833-897-1342 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ເສຍຄ່າທໍານຽມ.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Mienh Waac (Mien)

CAU FIM JANGX LONGX: Se gorngv meih qiemx longc mienh tengx faan benx meih nyei waac, douc waac lorz taux 1-833-897-1342 (TTY: 711). Ninh mbuo mbenc duqv maaih jaa-dorngx aengx caux gong-bou jau-louc tengx ziux goux waaic fangx mienh, dorh sou zoux benx braille, nqaapv bieqc domh zei-linh. Douc waac lorz 1-833-897-1342 (TTY: 711). Naaiv deix gong-bou jau-louc benx wangv-henh tengx hnangv oc.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ 1-833-897-1342 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪਾਹਜਤਾਵਾਂ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। 1-833-897-1342 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਇਹ ਸੇਵਾਵਾਂ ਬਿਨਾਂ ਕਿਸੇ ਸੁਲਕ ਹਨ।

Русский (Russian)

ВНИМАНИЕ: Если вы хотите получить помощь на вашем родном языке, позвоните по номеру 1-833-897-1342 (TTY: 711). Мы также предоставляем вспомогательные средства и услуги лицам с ограниченными возможностями, в том числе документы, набранные шрифтом Брайля или крупным шрифтом. Звоните по номеру телефона 1-833-897-1342 (TTY: 711). Эти услуги предоставляются бесплатно.



Español (Spanish)

ATENCIÓN: Si necesita ayuda en su idioma, llame al 1-833-897-1342 (TTY: 711). También hay ayudas y servicios disponibles para personas discapacitadas, como documentos en braille y letra grande. Llame al 1-833-897-1342 (TTY: 711). Estos servicios son sin cargo.

Tagalog (Filipino)

PAUNAWA: Kung kailangan mo ng tulong na nasa iyong wika, tumawag sa 1-833-897-1342 (TTY: 711). May available rin na mga tulong at serbisyo para sa mga taong may mga kapansanan, tulad ng mga dokumento na nasa braille at malaking print. Tumawag sa 1-833-897-1342 (TTY: 711). Walang bayad ang mga serbisyong ito.

ภาษาไทย (Thai)

หมายเหตุ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ โปรดโทร 1-833-897-1342 (TTY: 711) นอกจากนี้ยังมีอุปกรณ์ช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารในรูปแบบอักษรเบรลล์และการพิมพ์ด้วยตัวอักษรขนาดใหญ่ โทร 1-833-897-1342 (TTY: 711) บริการเหล่านี้ฟรี

Українська (Ukrainian)

УВАГА: Якщо ви бажаєте отримати допомогу вашою рідною мовою, зателефонуйте за номером 1-833-897-1342 (TTY: 711). Ми також надаємо допоміжні засоби та послуги особам з інвалідністю, зокрема документи, набрані шрифтом Брайля або великим шрифтом. Телефонуйте за номером 1-833-897-1342 (TTY: 711). Ці послуги надаються безкоштовно.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần giúp đỡ bằng ngôn ngữ của quý vị, hãy gọi số 1-833-897-1342 (TTY: 711). Cũng sẵn có sự trợ giúp và các dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi hoặc ở bản in khổ chữ lớn. Gọi số 1-833-897-1342 (TTY: 711). Các dịch vụ này được cung cấp miễn phí.



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Other languages

You can get this *Member Handbook* and other plan materials in other languages for free. Anthem Full Dual Advantage Aligned (HMO D-SNP) provides written translations from qualified translators. Call 1-833-897-1342 (TTY 711). The call is free. Refer to your *Member Handbook* to learn more about health care language assistance services such as interpreter and translation services.

Other formats

You can get this information, in a timely manner, in other formats such as braille, 20-point font large print, audio format, and accessible electronic formats (data CD) at no cost to you. Call 1-833-897-1342 (TTY 711). The call is free.

Language Access Services

Anthem Full Dual Advantage Aligned (HMO D-SNP) provides oral interpretation services, as well as sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You don't have to use a family member or friend as an interpreter. We discourage the use of family or friends, especially minors, as interpreters unless it's an emergency. Language access services, including interpreter services, are available for free. Interpreter services are available 24 hours a day, 7 days a week. For help in your language, or to get this handbook in a different language, call 1-833-897-1342 (TTY 711). The call is free.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Table of Contents

CHAPTER 1	Getting started as a member	4
CHAPTER 2	Important phone numbers and resources.....	15
CHAPTER 3	Using our plan's coverage for your health care and other covered services	31
CHAPTER 4	Benefits chart.....	52
CHAPTER 5	Getting your outpatient prescription drugs	131
CHAPTER 6	What you pay for your Medicare and Medi-Cal drugs	150
CHAPTER 7	Asking us to pay our share of a bill you received for covered services or drugs.	156
CHAPTER 8	Your rights and responsibilities.....	162
CHAPTER 9	What to do if you have a problem or complaint (coverage decisions, appeals, complaints)	209
CHAPTER 10	Ending your membership in our plan.....	251
CHAPTER 11	Legal notices.....	260
CHAPTER 12	Definitions of important words.....	264



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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 Partnership Plan LLC. 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 Full Dual Advantage Aligned (HMO D-SNP) Plan *Member Handbook*.
- ❖ Benefits and/or copayments may change on January 1, 2028.
- ❖ Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.
- ❖ 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 1-833-897-1342 (TTY: 711).
- ❖ Coverage under Anthem Full Dual Advantage Aligned (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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Anthem Full Dual Advantage Aligned (HMO D-SNP), a health plan that covers all of your Medicare services and coordinates all of your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you'll get from us. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

- A. Welcome to our plan 5
- B. Information about Medicare and Medi-Cal 5
 - B1. Medicare 5
 - B2. Medi-Cal..... 5
- C. Advantages of our plan 6
- D. Our plan’s service area 6
- E. What makes you eligible to be a plan member 7
- F. What to expect when you first join our health plan 8
- G. Your care team and care plan 9
 - G1. Care team..... 9
 - G2. Care plan..... 9
- H. Summary of Important Costs 9
 - H1. Monthly Medicare Part B Premium..... 9
- I. This *Member Handbook* 10
- J. Other important information you get from us 10
 - J1. Your Member ID Card 10
 - J2. *Provider and Pharmacy Directory* 11
 - J3. *List of Covered Drugs*..... 12
 - J4. *The Explanation of Benefits* 13
- K. Keeping your membership record up to date 13
 - K1. Privacy of personal health information (PHI) 14



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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 over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who 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**



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 isn't affected.

C. Advantages of our plan

You'll now get all your covered Medicare and Medi-Cal services from our plan, including prescription drugs. **You don't pay extra to join this health plan.**

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

- You can work with us for **most** 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:
 - o 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 that you may have from the medicines.
 - o Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Anthem Full Dual Advantage Aligned (HMO D-SNP): In most instances, you'll be enrolled in Anthem Full Dual Advantage Aligned (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Anthem Full Dual Advantage Aligned (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'll receive your Medi-Cal services through Anthem Full Dual Advantage Aligned (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at 1-833-897-1342 (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 if you have any questions.

D. Our plan's service area

Our service area includes these counties in California: Los Angeles.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of this *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 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 a United States citizen or national, or an eligible non-citizen **and**
- are currently eligible for Medi-Cal.
- If you lose your Medi-Cal eligibility but can be expected to regain it within the six month period of deemed continued eligibility, we'll continue to provide all Medicare benefits covered by Anthem Full Dual Advantage Aligned (HMO D-SNP). When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medi-Cal used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.

In addition, if you lose your Medi-Cal eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

For additional information about how a change in your Medi-Cal eligibility may affect your benefits and cost sharing, please contact Member Services.

We'll assist you to regain your Medi-Cal eligibility. If your Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Medi-Cal benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and cost-sharing assistance for which you again qualify. If you can't regain Medi-Cal within six months we'll disenroll you from Anthem Full Dual Advantage Aligned (HMO D-SNP). If you regain Medi-Cal eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Call Member Services for more information.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, 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 reach out to you annually to see if any of your needs have changed.

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, even if they're not in our network. We call this continuity of care. If they're 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.
 - o We determine an existing relationship by reviewing your available health information or information you give us.
 - o 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 can make this request by calling 1-833-897-1342. If you're at risk of harm, we must respond within three days.
 - o You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can make this request for providers of Durable Medical Equipment (DME) for at least 90 days until we authorize a new DME rental and have a network provider deliver the rental. Although you can't make this request for providers of transportation or other ancillary providers, you can make a request for services of transportation or other ancillary services not included in our plan.

After the continuity of care period ends, you'll need to use doctors and other providers in the Anthem Full Dual Advantage Aligned (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 this *Member Handbook* for more information on getting care.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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, your specialists, or other health professionals 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 or other services.

Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

A health worker or service coordinator reviews your Health Risk Assessment (HRA) and other health information to create or update your care plan. The care plan is made just for you, based on your needs, preferences, and any risks found in the HRA.

They decide when to follow up with you based on your health needs, doctor visits, and risk level. The care team works with you, your caregiver, and other team members to make sure your plan includes the right services and support covered by your benefits.

H. Summary of Important Costs

Our plan has no premium.

H1. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in **Section E** above, to be eligible for our plan, you must maintain your eligibility for Medi-Cal as well as have both Medicare Part



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A and Medicare Part B. For most Anthem Full Dual Advantage Aligned (HMO D-SNP) members, Medi-Cal pays for your Medicare Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medi-Cal isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

I. This Member Handbook

This *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 this *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* found on our website at the web address at the bottom of the page.

The contract is in effect for the months you're enrolled in our plan between January 1 and December 31, 2027.

J. Other important information you get from us

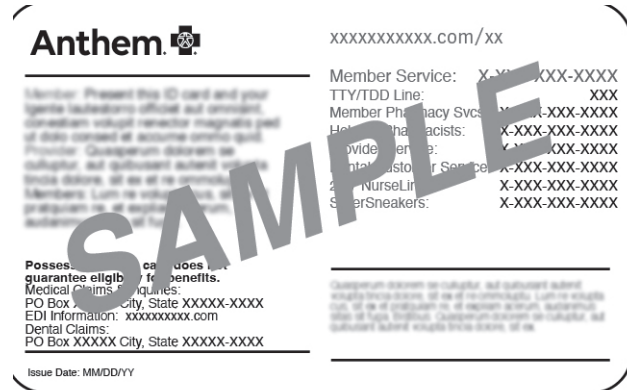
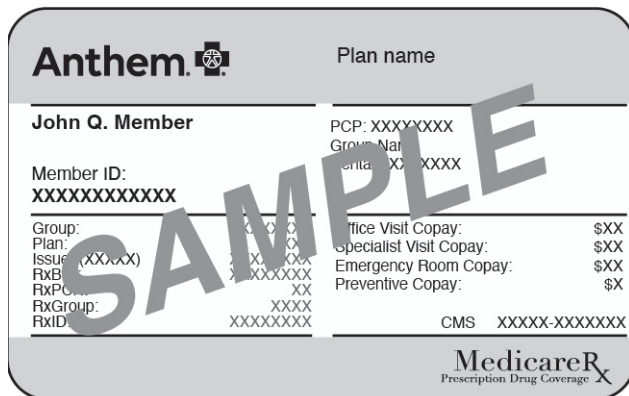
Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*, also known as a *Drug List or Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services, including Long-Term Services and Supports (LTSS), certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.



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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Medi-Cal card to get most services. Keep those cards in a safe place, in case you need them 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. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *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.
- Medi-Cal Dental benefits, at pharmacies for Medi-Cal Rx, Medi-Cal specialty mental health services and substance use disorder services, and In Home Supportive Services. See **Chapter 3, Section F1** for a list of Mental Health 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* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.

You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

list the pharmacies you may use to get your prescription drugs. Show both your Member ID and Medi-Cal cards at the pharmacy.

Definition of network providers

- Our network providers include:
 - o doctors, nurses, and other health care professionals that you can use as a member of our plan;
 - o clinics, hospitals, nursing facilities, and other places that provide health services in our plan;
and,
 - o LTSS, behavioral health services, home health agencies, durable medical equipment (DME) 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 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)

We included our List of DME with this *Member Handbook*. 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 **Chapter 3** and **Chapter 4** of this *Member Handbook* to learn more about DME equipment.

J3. List of Covered Drugs

Our plan has a *List of Covered Drugs*. We call it the *Drug List* for short. It tells you which drugs our plan covers. The drugs on this list are selected by our plan with the help of doctors and pharmacists. The *Drug List* must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your *Drug List* unless they've been removed and replaced as described in **Chapter 5, Section D**. Medicare approved the Anthem Full Dual Advantage Aligned (HMO D-SNP) *Drug List*.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *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 at the address at the bottom of the page.

J4. The Explanation of Benefits

When you use your Medicare Part D drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D 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 Medicare Part D drugs and the total amount we paid for each of your Medicare Part D drugs during the month. This EOB isn't a bill. The EOB has more information about the drugs you take. **Chapter 6** of this *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. The doctors, hospitals, pharmacists, and other providers in our plan's network use your membership record to know what services and drugs are covered and your cost-sharing amounts. Because of this, it's very important to help us keep your information up to date.

Tell us right away about the following:

- changes to your name, address, or 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 facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and,**
- if you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

If any information changes, call Member Services at the numbers at the bottom of the page.

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 this *Member Handbook*.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *Member Handbook*.

Table of Contents

- A. Member Services..... 16
- B. Your Care Coordinator 18
- C. Health Insurance Counseling and Advocacy Program (HICAP) 20
- D. Nurse Advice Call Line..... 20
- E. Behavioral Health Crisis Line 21
- F. Quality Improvement Organization (QIO) 22
- G. Medicare 22
- H. Medi-Cal..... 23
- I. Medi-Cal Managed Care and Mental Health Office of the Ombudsman 24
- J. County Social Services..... 25
- K. County Behavioral Health Services Agency 25
- L. California Department of Managed Health Care..... 26
- M. Health Consumer Alliance (HCA) 26
- N. Programs to Help People Pay for Drugs..... 27
 - N1. Extra Help from Medicare 27
 - N2. AIDS Drug Assistance Program (ADAP)..... 28
- O. Social Security..... 28
- P. Railroad Retirement Board (RRB)..... 29
- Q. Medicare Medi-Cal Ombudsperson Program..... 29
- R. Medi-Cal Dental 30



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. Member Services

CALL	1-833-897-1342. 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 don't speak English.
TTY	711. 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
FAX	1-877-664-1504
WRITE	P.O. Box 60007 Los Angeles, CA 90060-0007
WEBSITE	www.anthem.com/ca

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
 - o 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.
 - o Call us if you have questions about a coverage decision about your health care.
 - o To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your health care
 - o 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.
 - o To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Member Services.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
 - You can call us and explain your complaint at 1-833-897-1342.
 - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above to contact Member Services and **Chapter 9** of this *Member Handbook*).
 - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. 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 Medicare Medi-Cal Ombudsperson Program by calling 1-855-501-3077.
 - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.
- coverage decisions about your drugs
 - A coverage decision about your drugs is a decision about:
 - your benefits and covered drugs **or**
 - the amount we pay for your 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 (www.medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273.
 - For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your drugs
 - An appeal is a way to ask us to change a coverage decision.
 - For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- complaints about your drugs



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- o You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
- o If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)
- o You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- o For more on making a complaint about your prescription drugs, refer to **Chapter 9** of this *Member Handbook*.
- payment for health care or drugs you already paid for
 - o For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
 - o 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 this *Member Handbook*.

B. Your Care Coordinator

At Anthem Full Dual Advantage Aligned (HMO D-SNP), you will have the support of a care coordinator to assist you before, during and after a health event.

When you become an Anthem Full Dual Advantage Aligned (HMO D-SNP) 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 1-833-897-1342 (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. to find a care coordinator to meet your needs.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

CALL	1-833-897-1342. 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	711. This call is free. Monday through Friday from 8 a.m. to 8 p.m.
FAX	1-877-664-1504
WRITE	P.O. Box 60007 Los Angeles, CA 90060-0007
WEBSITE	www.anthem.com/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 dental benefits
- questions about transportation to medical appointments
- questions about Long-term Services and Supports (LTSS), including Community-Based Adult Services (CBAS) and Nursing Facilities (NF)

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
- home health care
- In-Home Supportive Services (IHSS) through your county social service agency
- sometimes you can get help with your daily health care and living needs



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

C. Health Insurance Counseling and Advocacy Program (HICAP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-434-0222
	24 hours a day, 7 days a week.
TTY	1-800-735-2929
	This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	2880 Gateway Oaks Drive, Suite 200 Sacramento, CA 95833
WEBSITE	https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/

Contact HICAP for help with:

- questions about Medicare
- HICAP counselors can answer your questions about changing to a new plan and help you:
 - o understand your rights,
 - o understand your plan choices,
 - o answer questions about switching plans,
 - o make complaints about your health care or treatment, **and**
 - o assist with billing or claims issues.

D. 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Sometimes you will have health questions later 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	1-855-658-9249. This call is free.
	24 hours a day, 7 days a week.
	We have free interpreter services for people who don't speak English.
TTY	711. This call is free.
	24 hours a day, 7 days a week.

E. Behavioral Health Crisis Line

The Behavioral Health Crisis Line connects members to licensed behavioral health professionals that can provide help with most urgent mental health and substance use concerns. If you are experiencing emotional or mental pain or distress, call the Behavioral Health Crisis Line at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. This is a free call. We are here to help you with problems like substance use disorder, stress, depression or anxiety. We can get you the support you need to feel better. If you are in danger or need immediate medical attention, call 911.

CALL	1-833-897-1342. This call is free.
	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.
	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
- behavioral health and substance use disorder screening
- behavioral health and substance use assessment
- behavioral health and/or substance use referral
- behavioral health and/or substance use crisis counseling



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

F. Quality Improvement Organization (QIO)

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

CALL	1-877-588-1123
TTY	711
WRITE	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
WEBSITE	https://www.commencehealthqio.cms.gov/en

Contact Commence Health (California's Quality Improvement Organization) for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
 - o have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
 - o think your hospital stay is ending too soon, **or**
 - o 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 over, 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. This agency contracts with Medicare Advantage organizations, including our plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 difficulty with hearing or speaking. You must have special telephone equipment to call it.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots, or vaccines, and yearly “wellness” visits) • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. To submit a complaint to Medicare, go to www.medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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, children and youth in foster care, and pregnant women. Medi-Cal is financed by state and federal government funds.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Medi-Cal benefits include medical, dental, behavioral health, and long-term services and supports.

You're enrolled in Medicare and in Medi-Cal. If you have questions about your Medi-Cal benefits, call your plan care coordinator. If you have questions about Medi-Cal plan enrollment, call Health Care Options.

CALL	1-800-430-4263
	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. Medi-Cal Managed Care and Mental Health Office of the Ombudsman

The Office of the Ombudsman helps solve problems from a neutral standpoint to ensure that our members receive all medically necessary covered services. They will listen, answer your questions, analyze your situation, explain policies and procedures, provide information, advice, and options, and suggest appropriate referrals. It's their job to help develop fair solutions to health care access problems. They aren't connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-452-8609
	Monday through Friday, 8 a.m. to 5 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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

EMAIL	MMCDOmbudsmanOffice@dhcs.ca.gov
WEBSITE	www.dhcs.ca.gov/services/MH/Pages/mh-ombudsman.aspx

J. County Social Services

If you need help with your IHSS and Medi-Cal eligibility benefits, contact your local County Social Services agency.

Contact your County Social Services agency to apply for In-Home Supportive Services, which will help pay for services provided to you so that you can remain safely in your own home. Types of services may include help with preparing meals, bathing, dressing, laundry, shopping or transportation.

Contact your County Social Services agency for any questions about your Medi-Cal eligibility.

In the county of Los Angeles	
CALL	1-866-613-3777. This call is free. Monday through Friday 9 a.m. to 5 p.m.
WRITE	2601 Wilshire Blvd Los Angeles, CA 90057
WEBSITE	www.dpss.lacounty.gov

K. County Behavioral Health Services Agency

Medi-Cal specialty mental health services and substance use disorder services are available to you through the county if you meet access criteria.

In the county of Los Angeles	
CALL	1-800-654-7771. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who don't speak English.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

In the county of Los Angeles

TTY	711. This call is free. 24 hours a day, 7 days a week.
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Contact the county Behavioral Health agency for help with:

- questions about specialty mental health services provided by the county
- questions about substance use disorder services provided by the county

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 a.m. and 6 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. Health Consumer Alliance (HCA)

The Health Consumer Alliance (HCA) is a statewide partnership that offers free on-line, over-the-phone, or in-person legal assistance to help California residents struggling to get or maintain health coverage and resolve problems with their health plans. To learn more about the HCA or to get possible assistance, call 1-888-804-3536 or visit www.healthconsumer.org/.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

N. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

N1. Extra Help from Medicare

Because you're eligible for Medi-Cal, you qualify for and are getting “Extra Help” from Medicare to pay for your drug plan costs. You don't need to do anything to get this “Extra Help.”

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 difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

Please fax or mail a copy of your paperwork, showing you qualify for a subsidy, using the fax number or address shown on the back cover of this document. Below are some examples of the paperwork you can provide:

- A copy of your California Medi-Cal (Medicaid) card if it includes your eligibility date during the period in question;
- A copy of a letter from the state of SSA showing Medicare Low-Income Subsidy status;
- A copy of a state document that confirms active Medi-Cal status during the period of time in question;
- Evidence of recent point-of-sale Medi-Cal billing and payment in the pharmacy's patient profile, backed up by one of the above indicators after the point-of-sale.

If you have been a resident of a long term care (LTC) facility (like a nursing home), instead of providing one of the items above, you should provide one of the items listed below. If you do, you may be eligible for the highest level of subsidy.

- A remittance from the facility showing Medi-Cal payment for a full calendar month for you during the period of time in question;
- A copy of a state document that confirms Medi-Cal payment to the facility for a full calendar month on your behalf; or



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- A screen print from the state's Medi-Cal systems showing your institutional status, based on at least a full calendar month stay, for Medi-Cal payment purposes during the period of time in question.

Once we have received your paperwork and verified your status, we will call you so you can begin filling your prescriptions at the low-income copayment.

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them debt, we may make the payment directly to the pharmacy. If the state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

N2. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through The AIDS Drug Assistance Program (ADAP). Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050.

O. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

CALL	1-800-772-1213
	Calls to this number are free.
	Available 8 a.m. to 7 p.m., Monday through Friday.
	You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778
	This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

WEBSITE	www.ssa.gov
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P. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you get Medicare through the RRB, let them know if you move or change your mailing address. For questions about your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press “1” to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number aren't free.
WEBSITE	www.rrb.gov

Q. Medicare Medi-Cal Ombudsperson Program

The Medicare Medi-Cal Ombudsperson Program 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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

- appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- medical billing
- IHSS (In-Home Supportive Services)

The Medicare Medi-Cal Ombudsperson Program assists with complaints, appeals, and hearings. The phone number for the Ombudsperson Program is 1-855-501-3077.

R. Medi-Cal Dental

Certain dental services are available through Medi-Cal Dental, including but not limited to, services such as:

- initial examinations, X-rays, cleanings, sealants, and fluoride treatments;
- restorations and crowns;
- root canal therapy; and
- partial and complete dentures, adjustments, repairs, and relines

Dental benefits are available through Medi-Cal Dental Fee-for-Service (FFS) and Dental Managed Care (Dental MC).

CALL	1-800-322-6384 The call is free. Medi-Cal Dental FFS Program representatives are available to assist you from 8 a.m. to 5 p.m., Monday through Friday.
TTY	1-800-735-2922 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.dental.dhcs.ca.gov smilecalifornia.org

Instead of Medi-Cal Dental Fee-For-Service, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans, 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 a.m. to 6 p.m. The call is free. Dental managed care plan contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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're 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 this *Member Handbook*.

Table of Contents

A. Information about services and providers.....	33
B. Rules for getting services our plan covers.....	33
C. Your care coordinator.....	34
C1. What a care coordinator is	34
C2. How you can contact your care coordinator	35
C3. How you can change your care coordinator	35
D. Care from providers.....	35
D1. Care from a primary care provider (PCP).....	35
D2. Care from specialists and other network providers	37
D3. When a provider leaves our plan.....	38
D4. Out-of-network providers.....	39
E. Long-term services and supports (LTSS)	40
F. Behavioral health (mental health and substance use disorder) services	40
F1. Medi-Cal behavioral health services provided outside our plan	40
G. Transportation services.....	42
G1. Non-Emergency Medical Transportation	42
G2. Non-medical transportation.....	43
H. Covered services in a medical emergency, when urgently needed, or during a disaster	44
H1. Care in a medical emergency.....	44
H2. Urgently needed care.....	46
H3. Care during a disaster	47
I. What if you're billed directly for covered services	47
I1. What to do if our plan doesn't cover services.....	47
J. Coverage of health care services in a clinical research study	48
J1. Definition of a clinical research study.....	48
J2. Payment for services when you participate in a clinical research study.....	48



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

J3. More about clinical research studies..... 48

K. How your health care services are covered in a religious non-medical health care institution..... 49

 K1. Definition of a religious non-medical health care institution 49

 K2. Care from a religious non-medical health care institution 49

L. Durable medical equipment (DME)..... 49

 L1. Getting DME as a member of our plan..... 49

 L2. DME ownership if you switch to Original Medicare 50

 L3. Oxygen equipment benefits as a member of our plan 50

 L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan 51



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment, and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *Member Handbook*.

Providers are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. 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 all services covered by Medicare, and most Medi-Cal services. This includes certain behavioral health and LTSS.

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

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean services that are reasonable and necessary to diagnose and treat your medical condition. 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)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (go to **Section D1** for more information).
 - In most cases, your network PCP or our plan must give you approval before you can use a provider that isn't 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 referrals from your PCP for emergency care or urgently needed care, to use a woman's health provider, or any other services listed in **Section D1**.
- **You must get your care from network providers** (for more information, go to **Section D** in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

This means that you'll have to pay the provider in full for services you get. Here are some cases when this rule doesn't apply:

- o If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section H**).
- o If you need care that our plan covers and our network providers can't provide it, you can get care from an out-of-network provider. However, a prior authorization may be required. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4**.
- o If you need 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 care from an out-of-network provider.
- o If you're a new member to 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 this *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'll no longer cover your care if you continue to use providers that aren't in our network.

Other Health Coverage: You must utilize all other health coverage prior to Medi-Cal when the same service is available under your primary health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to Medicare, covering allowable costs not paid by Medicare or other health coverage up to the Medi-Cal rate.

New members to Anthem Full Dual Advantage Aligned (HMO D-SNP): In most instances, you'll be enrolled in Anthem Full Dual Advantage Aligned (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Anthem Full Dual Advantage Aligned (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for up to two months. After that, you'll receive your Medi-Cal services through Anthem Full Dual Advantage Aligned (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call the number at the bottom of the page 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. Care coordinators partner with patients to get the care they need to be healthy.

A care coordinator helps patients:



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does 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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 Full Dual Advantage Aligned (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 1-833-897-1342 (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.

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.

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 1-833-897-1342 (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 can change your PCP for any reason, at any time. It's also 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 1-833-897-1342, (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 Full Dual Advantage Aligned (HMO D-SNP) Member ID Card with your new PCP's name and phone number.

Services you can get without approval from your PCP



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 covered services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our network is temporarily unavailable.

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. If you call Member Services before you leave the service area, we can help you receive dialysis while you're away.
- Flu shots and COVID-19 vaccine as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

Additionally, if you're an American Indian Member, you may get Covered Services from an Indian Health Care Provider of your choice, without requiring a referral from a Network PCP or Prior Authorization.

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

It is very important to get a referral (approval in advance) before you see a network contracted specialist or receive specialty services (with the exception of those services listed above under **Services you can get without approval from your PCP**). Please refer to **Chapter 4** for information about which services require referrals and/or prior authorizations.

For certain services provided by specialists, either your PCP or specialist will need to get prior approval from us. This is called getting "prior authorization." (For more information about this, see the Medical Benefits Chart in **Chapter 4**). When we give our decision, we base it on two things. First there are



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Medicare's and the state Medicaid program's rules. Second, there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you and that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for urgent care, emergency care or renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Member Services. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

A written referral may be for a single visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.

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 these rights and protections that are summarized below:

- Even if our network of providers changes during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three years.
 - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past three months.
- We'll help you select a new qualified in-network provider to continue managing your health care needs.



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- If you're currently undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies from another provider in our network. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage 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 Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

D4. Out-of-network providers

If you use an out-of-network provider, the provider must accept Medicare and/or Medi-Cal.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.
- Except for emergency care, urgent care, or sensitive care, you must get pre-approval (prior authorization) from us before you visit a provider outside the network. If you do not get pre-approval (prior authorization) and you go to a provider outside the network for care that is not emergency care, urgent care, or sensitive care, you might have to pay for care you got from that provider.
- 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**.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

E. Long-term services and supports (LTSS)

LTSS can help you stay at home and avoid a hospital or skilled nursing facility stay. You have access to certain LTSS through our plan, including skilled nursing facility care, Community Based Adult Services (CBAS), and Community Supports. Another type of LTSS, the In-Home Supportive Services program, is available through your county social service agency.

Referrals are submitted to the LTSS Service Coordination Team. Once a referral is received and processed, a service coordinator is assigned to the member. The service coordinator will then reach out to the member to provide information about LTSS benefits, including the In-Home Supportive Services program and CBAS. They'll make the necessary referrals and support the member throughout the referral process until the services are in place.

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

You have a right to access medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan doesn't provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through: the Los Angeles County Department of Mental Health.

F1. 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 may include:

- mental health services
- medication support services
- day treatment intensive services
- day rehabilitation
- crisis intervention services
- crisis stabilization services
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services



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- targeted case management
- justice-involved reentry
- assertive community treatment (ACT)
- forensic assertive community treatment (FACT)
- coordinated specialty care (CSC) for first episode psychosis (FEP)
- clubhouse services
- enhanced community health worker (CHW) Services
- supported Employment
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services

Drug Medi-Cal (DMC) services provided by the Los Angeles County Department of Mental Health include:

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)

Drug Medi-Cal Organized Delivery System (DMC-ODS) services are available to you through the Los Angeles County Department of Mental Health if you meet criteria to receive these services. DMC-ODS Services include:

- outpatient treatment services
- intensive outpatient treatment services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program



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- recovery services
- care coordination
- inpatient treatment services

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

The Los Angeles County Department of Mental Health offers evaluation, assessment and treatment to determine the criteria that meets medical necessity and best meets members needs.

The health plan provides care coordination by:

- Helping educate you and providers about Medi-Cal benefits and services, helping you obtain these services and referrals to the county for provision of services and/or follow up.
- When a member is referred for mental health services and is identified as having an alcohol or drug use diagnosis that is referred and/or treated by Drug Medi-Cal, the Plan's Care Coordinator will follow best practice guidelines in obtaining appropriate consent and coordinating care between PCP and Drug Medi-Cal providers.

G. Transportation services

G1. Non-Emergency Medical Transportation

You're entitled to non-emergency medical transportation (NEMT) if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. NEMT can be provided for all Medi-Cal covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need NEMT, 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 NEMT, they'll prescribe it by completing a form and submitting it to Anthem Full Dual Advantage Aligned (HMO D-SNP) for approval. Depending on your medical need, you may be able to get approval for up to 12 months. Your PCP will reassess your need for NEMT as necessary or upon the expiration of your prescription, and may re-approve the NEMT for up to 12 months.

NEMT is an ambulance, litter van, wheelchair van, or air transport. Anthem Full Dual Advantage Aligned (HMO D-SNP) allows the lowest cost covered transportation mode and most appropriate NEMT 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 Full Dual Advantage Aligned (HMO D-SNP) won't pay for an ambulance. You're only entitled to air transport if your medical condition makes any form of ground transportation impossible.

NEMT must be used when:



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- You physically or medically need it as determined by written authorization from your PCP because you aren't 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 Full Dual Advantage Aligned (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 Full Dual Advantage Aligned (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 won't be provided if Medicare or Medi-Cal doesn't cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, Anthem Full Dual Advantage Aligned (HMO D-SNP) will help you schedule your transportation. A list of covered services is in **Chapter 4** of this *Member Handbook*. Transportation isn't covered outside Anthem Full Dual Advantage Aligned (HMO D-SNP)'s network or service area unless pre-authorized.

G2. Non-medical transportation

Non-medical transportation (NMT) 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're:

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

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

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Anthem Full Dual Advantage Aligned (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 can't 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

To ask for a ride for services that have been authorized, call Anthem Full Dual Advantage Aligned (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 Indian Members may contact their local Indian Health Clinic to ask for non-medical transportation.

Non-medical transportation limits

Anthem Full Dual Advantage Aligned (HMO D-SNP) provides the lowest cost NMT that meets your needs from your home to the closest provider where an appointment is available. **You can't drive yourself or be reimbursed directly.**

NMT **doesn't** 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're in a wheelchair and are unable to move in and out of the vehicle without help from the driver.
- The service isn't covered by Medicare or Medi-Cal.

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

H1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as illness, severe pain, serious injury, or a medical condition that's quickly getting worse. 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 life or to that of your unborn child; **or**
- loss of 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:
 - o There isn't enough time to safely transfer you to another hospital before delivery.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- o 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 the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PCP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license, even if they're not part of our network.
- **As soon as possible, tell our plan about your emergency.** We 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 telling us. For more information call Member Services at **1-833-897-1342** (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

Our plan covers ambulance services in situations when getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They'll 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'll 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.

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 Full Dual Advantage Aligned (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



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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**.

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.

However, 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 for getting it. Refer to the next section.

H2. 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 an unforeseen illness or injury.

Urgently needed care in our plan's service area

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 isn't possible or reasonable to get to a network provider, given your time, place or circumstances, we 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. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed, even if you're outside our plan's service area or our plan network is temporarily unavailable.

Our plan covers worldwide emergency and urgently needed care services outside the United States and its territories under the following circumstances: if you're traveling outside the United States for less than



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six months. Prescriptions purchased outside of the country are not covered even for urgent or emergency care. For more information, see the Benefits Chart in **Chapter 4** of this document.

H3. Care during a disaster

If the governor of California, 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're still entitled to care from our plan.

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

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your drugs at an out-of-network pharmacy. Refer to **Chapter 5** of this *Member Handbook* for more information.

I. What if you're billed directly for covered services

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

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

II. What to do if our plan doesn't 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 this *Member Handbook*), **and**
- that you get by following plan rules.

If you get services that our plan doesn't cover, **you pay the full cost yourself**, unless it's covered by another Medi-Cal program outside our plan.

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 won't pay for your services, you have the right to appeal our decision.

Chapter 9 of this *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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

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

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us, but we encourage you to tell us or your primary care provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you'll take part in a clinical trial.

J2. Payment for services when you participate 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's 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 **hasn't** approved, you pay any costs for being in the study.

J3. 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/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

K1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we 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).

K2. 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're against getting medical treatment that's "non-excepted."

- "Non-excepted" medical treatment is any care or treatment that's **voluntary and not required** by any federal, state, or local law.
- "Excepted" medical treatment is any care or treatment that's **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 only covers non-religious aspects of care.
- If you get services from this institution 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're admitted to the facility, or your stay **won't** be covered.

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

L. Durable medical equipment (DME)

L1. Getting 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,



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intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you **won't** own the rented DME items, 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 **won't** own the equipment.

L2. DME ownership if you switch to Original Medicare

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

Note: You can find definitions of Original Medicare and MA Plans in **Chapter 12**. You can also find more information about them in the *Medicare & You 2027* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

If you no longer have Medi-Cal, you'll have to make 13 payments in a row under Original Medicare, or you'll have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you didn't become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments don't count toward the payments you need to make after leaving our plan.**

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

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents



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- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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. Medicare and Medi-Cal cover these payments if you're still enrolled in Medicare and Medi-Cal.

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 five years if medically necessary

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

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new five-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 five years as long as oxygen equipment is medically necessary.

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



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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 this *Member Handbook*.

New members to Anthem Full Dual Advantage Aligned (HMO D-SNP): In most instances you'll be enrolled in Anthem Full Dual Advantage Aligned (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Anthem Full Dual Advantage Aligned (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'll receive your Medi-Cal services through Anthem Full Dual Advantage Aligned (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at **1-833-897-1342** (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 if you have any questions.

Table of Contents

A. Your covered services.....	53
B. Rules against providers charging you for services.....	53
C. About our plan’s Benefits Chart.....	53
D. Our plan’s Benefits Chart	59
E. Community Supports.....	122
F. Benefits covered outside of our plan.....	123
F1. California Community Transitions (CCT).....	123
F2. Medi-Cal Dental.....	124
F3. In-Home Supportive Services (IHSS)	124
F4. 1915(c) Home and Community Based Services (HCBS) Waiver Programs.....	125
F5. County Behavioral Health Services Provided Outside Our Plan (Mental Health and Substance Use Disorder Services)	127
G. Benefits not covered by our plan, Medicare, or Medi-Cal.....	129



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A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that aren't covered. Information about drug benefits is in **Chapter 5** of this *Member Handbook*. This chapter also explains limits on some services.

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

If you need help understanding what services are covered, call Member Services at 1-833-897-1342 (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.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network 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 this *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. (Drug coverage is in **Chapter 5**.) 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 **don't** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered 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 facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.



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- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed care or unless our plan or a network provider gave you a referral. This means that you may need to pay the provider in full for out-of-network services you get. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that isn't your PCP or use other providers in our plan's network. This is called a referral. **Chapter 3** of this Member Handbook has more information about getting a referral and when you **don't** need one.
- 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 (PA). We mark covered services in the Benefits Chart that need PA with a footnote.
- If our plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2027* handbook. View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- If you lose your Medi-Cal eligibility but can be expected to regain it within the six month period of deemed continued eligibility, we'll continue to provide all Medicare benefits covered by Anthem Full Dual Advantage Aligned (HMO D-SNP). However, your Medi-Cal coverage may end sooner than your Medicare coverage with us. When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medi-Cal used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.

In addition, if you lose your Medi-Cal eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

For additional information about how a change in your Medi-Cal eligibility may affect your benefits and cost sharing, please contact Member Services.

We'll assist you to regain your Medi-Cal eligibility. If your Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Medi-Cal benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and



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cost-sharing assistance for which you again qualify. If you can't regain Medi-Cal within six months we'll disenroll you from Anthem Full Dual Advantage Aligned (HMO D-SNP). If you regain Medi-Cal eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.

Important Benefit Information for Members with Certain Chronic Conditions

If you're diagnosed with any of the chronic condition(s) listed below and your condition:

1. Is life threatening or significantly limits your overall health or function; AND
2. Has a high risk of hospitalization or other adverse health outcomes; AND
3. Requires intensive care coordination

you may be eligible for special supplemental benefits for the chronically ill.

Meeting these conditions must be demonstrated by one or more of the following:

- One or more inpatient admissions (inclusive of behavioral health) related to the chronic condition in the last 12 months, OR
- One or more urgent care or emergency room visits related to the chronic condition in the last 12 months, OR
- Two or more outpatient visits related to the chronic condition (including primary care or specialty care visits) in the last 12 months, OR
- Is a patient who requires home health visits related to the chronic condition, OR
- Is a patient who has an impairment in daily living activities related to the chronic condition (bathing, dressing, toileting, transferring, and eating) or cognitive impairments, OR
- Is a patient with a chronic condition and a need for one or more durable medical equipment (DME) in the outpatient setting (including but not limited to): group 3 power / manual wheelchair, non-invasive ventilation (NIV), wound vacuums, bipap machines, mechanical in-exsufflation devices, group 2 or group 3 mattresses

Eligible Conditions:

- Chronic alcohol use disorder and other substance use disorders;
- Autoimmune disorders:
 - o Polyarteritis nodosa,
 - o Polymyalgia rheumatica,
 - o Polymyositis,



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- o Dermatomyositis,
 - o Rheumatoid arthritis,
 - o Systemic lupus erythematosus,
 - o Psoriatic arthritis, and
 - o Scleroderma;
- Cancer;
- Cardiovascular disorders:
 - o Cardiac arrhythmias,
 - o Coronary artery disease,
 - o Peripheral vascular disease, and
 - o Valvular heart disease;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
 - o Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C: 5.7-6.4%)
- Overweight, Obesity, and Metabolic Syndrome;
- Chronic gastrointestinal disease:
 - o Chronic liver disease,
 - o Non-alcoholic fatty liver disease (NAFLD),
 - o Hepatitis B,
 - o Hepatitis C,
 - o Pancreatitis,
 - o Irritable bowel syndrome, and
 - o Inflammatory bowel disease;
- Chronic kidney disease (CKD):
 - o CKD requiring dialysis/End-stage renal disease (ESRD), and
 - o CKD not requiring dialysis;



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- Severe hematologic disorders:
 - Aplastic anemia,
 - Hemophilia,
 - Immune thrombocytopenic purpura,
 - Myelodysplastic syndrome,
 - Sickle-cell disease (excluding sickle-cell trait), and
 - Chronic venous thromboembolic disorder;
- HIV/AIDS;
- Chronic lung disorders:
 - Asthma,
 - Chronic bronchitis,
 - Cystic Fibrosis,
 - Emphysema,
 - Pulmonary fibrosis,
 - Pulmonary hypertension, and
 - Chronic Obstructive Pulmonary Disease (COPD);
- Chronic and disabling mental health conditions:
 - Bipolar disorders,
 - Major depressive disorders,
 - Paranoid disorder,
 - Schizophrenia,
 - Schizoaffective disorder,
 - Post-traumatic stress disorder (PTSD),
 - Eating Disorders, and
 - Anxiety disorders;
- Neurologic disorders:
 - Amyotrophic lateral sclerosis (ALS),



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- o Cerebral Palsy,
- o Epilepsy,
- o Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia),
- o Huntington's disease,
- o Multiple sclerosis,
- o Parkinson's disease,
- o Polyneuropathy,
- o Fibromyalgia,
- o Chronic fatigue syndrome,
- o Spinal cord injuries,
- o Spinal stenosis,
- o Stroke-related neurologic deficit, and
- o Traumatic brain injury;
- Stroke;
- Post-organ transplantation care;
- Immunodeficiency and Immunosuppressive disorders;
- Conditions that may cause cognitive impairment:
 - o Alzheimer's disease,
 - o Intellectual and developmental disabilities,
 - o Traumatic brain injuries,
 - o Disabling mental illness associated with cognitive impairment, and
 - o Mild cognitive impairment;
- Conditions that may cause similar functional challenges and require similar services:
 - o Spinal cord injuries,
 - o Paralysis,
 - o Limb loss,
 - o Stroke, and



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- o Arthritis;
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell;
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
- Other
 - o Chronic hypertension;
 - o Osteoporosis, and
 - o Chronic back pain

The plan will need to obtain verification of the chronic condition through your medical claims history or from your healthcare provider.

- For more details, go to the Special Supplemental Benefits for the Chronically Ill row in the Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

All preventive services are free. This apple  shows the preventive services in the Benefits Chart.

D. Our plan’s Benefits Chart

Covered Service		What you pay
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	\$0
	Active Fitness – Supplemental The Active Fitness benefit provides a spending allowance of \$25.00 every month on your Benefits Prepaid Card. This spending allowance may be used for access fees or lesson/clinic costs at sports facilities for golf, swimming, and tennis. The allowance cannot be applied to merchandise or other services. This benefit continues on the next page.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Active Fitness – Supplemental (continued) The spending allowance amount is automatically loaded onto your Benefits Prepaid Card at the beginning of each month. 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. Unused amounts carry over each month and expire at the end of the plan year. If your Benefits Prepaid Card is not accepted for payment or in the event of a card transaction failure, you may submit for reimbursement by providing a legible receipt as proof of payment for access fees at sports facilities for golf, swimming, and tennis. Contact information is listed on the back of your Benefits Prepaid Card. A reimbursement request must be submitted within 90 days of the date of payment on your receipt.	\$0.00 copay for the Active Fitness benefit.
Acupuncture We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they're medically necessary. We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Acupuncture (continued) Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's 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. <i>Prior authorization and referral may be required.</i>	
Acupuncture - Supplemental This plan covers supplemental acupuncture, which is an alternative method to treat illness or pain. Your treatment plan may require verification of medical necessity. <i>Prior authorization may be required.</i>	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay per visit. This plan offers coverage for unlimited visits every year.



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Covered Service	What you pay
 Alcohol misuse screening and counseling We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but aren't 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're able and alert during counseling) with a qualified primary care provider (PCP) 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.	\$0
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter). 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 (non-emergent) must be approved by us. In cases that aren't 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. <i>Prior authorization may be required.</i>	\$0
Annual routine physical exam - Supplemental 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. This benefit is continued on the next page.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for one



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Covered Service		What you pay
	Annual routine physical exam (continued)	routine physical exam each calendar year.
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit. However, you don't need to have had a Welcome to Medicare visit to get annual wellness visits after you've had Part B for 12 months.	\$0
	Asthma preventive services 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 over • clinical breast exams once every 24 months	\$0



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Covered Service	What you pay
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • coronary artery bypass surgery • stable angina pectoris (chest pain) • heart valve repair or replacement • coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period. <i>Prior authorization may be required.</i>	\$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 (PCP) 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're eating well.	\$0



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Covered Service	What you pay
 Cardiovascular (heart) disease screening tests 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
 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 three 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 five years	\$0
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment Additional services may be available. Contact your Care Coordinator for assistance. <i>Prior authorization and referral may be required.</i>	\$0
 Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (ten years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. This benefit is continued on the next page.	\$0



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Covered Service	What you pay
 Colorectal cancer screening (continued) • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	



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Covered Service	What you pay
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
Dental Services We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we don't cover is available through Medi-Cal Dental, described in Section G2 below. We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. <i>Prior authorization may be required.</i>	\$0
Dental Services - Supplemental This plan provides additional dental coverage not covered by Original Medicare. This plan covers up to a \$4,000 allowance for covered preventive and comprehensive dental services every year. Any amount not used at the end of the plan year will expire. Our dental allowance can be used toward approved dental services: Diagnostic and Preventive Services: • 2 Exams • 2 X-rays • 2 Cleanings This benefit continues on the next page.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: In-network dental services are covered. To be covered in-network, dental services must be performed by a provider that is contracted with our



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Covered Service	What you pay
Dental Services - Supplemental (continued) • 2 Fluoride treatments • Other preventive services (treatment to prevent oral disease and stop tooth decay) • Other diagnostic services (specialized X-rays) Comprehensive Dental Services: • Restorative (fillings, crowns and related tooth restoration services) • Endodontics (root canals, pulp & root therapy, and other related services) • Periodontics (deep cleaning services and other gum-related treatments) • Fixed Prosthodontics (bridges) • Removable Prosthodontics (complete or partial dentures, denture repairs, and related services) • Oral and Maxillofacial Surgery (teeth extractions, surgical repairs, and other related specialized procedures) • Adjunctive General Services (emergency treatment, sedation, anesthesia, night guards) Please note: Prior authorization is required for restorative crowns, bridges, some endodontic, some periodontal services, and some oral and maxillofacial surgery services prior to treatment being performed. Services must meet our clinical criteria and guidelines to be approved and covered. Other dental services are subject to limitations. For detailed information on prior authorization, limitations, and exclusions, please refer to the supplemental dental section immediately following this Medical Benefits Chart. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Services beyond Medicare limitations and exclusions would be evaluated under Medicaid. This benefit continues on the next page.	approved dental vendor to provide supplemental dental services. When using an in-network provider, you pay: \$0.00 copay for covered preventive dental services designed to help prevent disease. \$0.00 copay for covered comprehensive dental services. Out-of-network: Out-of-network dental services are NOT covered. Dental services performed by a provider that is not contracted with our approved dental vendor are considered out-of-network. When using an out-of-network provider, you pay: 100% of all the cost of dental services. Talk to your provider and confirm all coverage, costs, and codes prior to services being performed. For more information or to find a provider, call the Dental Member Services number located on the



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Covered Service	What you pay
Dental Services - Supplemental (continued) 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 • Partial and complete dentures, adjustments, repairs, and relines CALL 1-800-322-6384 The call is free. Dental benefits are available through Medi-Cal Dental Fee-for Service and Dental Managed Care (DMC) Programs. Medi-Cal Dental Fee-For-Service and Dental Managed Care (DMC) Programs. Medi-Cal Dental Fee-For-Service Program representatives are available to assist you from 8 a.m. to 5 p.m., Monday through Friday TTY 1-800-735-2922. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. WEBSITE http://www.dental.dhcs.ca.gov/ In addition to the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans, 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 a.m. to 6 p.m. The call is free.	back of your member ID card.
 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/or referrals.	\$0
 Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: This benefit is continued on the next page	\$0



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Covered Service	What you pay
 Diabetes screening (continued) • 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're overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	
 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. This benefit is continued on the next page	\$0



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Covered Service	What you pay
 Diabetic self-management training, services, and supplies (continued) Blood Glucose Monitors and Supplies: This plan covers one blood glucose monitor every calendar year. Test strips are covered for 102 units every 30 days and up to 306 units for a 90-day supply. This plan covers only Freestyle (made by Abbott) and Accu-Chek® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. If you are using a brand of diabetic test strips that is not covered by our plan, we will continue to cover it for up to two fills during the first 90 days after joining our plan. During this time, talk with your doctor to decide what brand is medically best for you. Blood glucose test strips and glucometers 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. Lancets: Lancets are covered for 100 units every 30 days and up to 300 units for a 90-day supply. Lancets may be purchased at either a network retail pharmacy or our mail order pharmacy. However, lancets are limited to the following manufacturers: Freestyle, Trividia, Accu-Chek®, HTL-Strefa, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. During this time, talk with your doctor to decide what brand is medically best for you. Continuous Glucose Monitors (CGMs): This benefit is continued on the next page	



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Covered Service	What you pay
 Diabetic self-management training, services, and supplies (continued) 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. Continuous Glucose Monitors are available as a covered benefit for diabetics who require the use of insulin and have difficulty controlling their blood sugar levels. This plan only covers FreeStyle Libre® (made by Abbott) and Dexcom 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. Coverage limitations: • 2-3 sensors per month depending on the receiver • One receiver every 2 years Insulin pumps: Insulin pumps are different than a CGM and can be purchased through a DME provider or at a network pharmacy. <i>Prior authorization and referral may be required.</i>	
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. Up to nine additional postpartums may be provided as well.	\$0



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Covered Service	What you pay
Durable medical equipment (DME) and related supplies Refer to Chapter 12 of this <i>Member Handbook</i> 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 • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area doesn’t carry a particular brand or maker, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.anthem.com/ca. 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. This benefit is continued on the next page	\$0



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Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) 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. You must get durable medical equipment through our approved suppliers. You cannot purchase these items from a pharmacy. <i>Prior authorization may be required.</i>	
Emergency Care Emergency care means services that are: • given by a provider trained to give emergency services, • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • 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 • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: - o There isn't enough time to safely transfer you to another hospital before delivery. - o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Emergency care coverage is worldwide. 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 This benefit is continued on the next page	\$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move 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 approves your stay. \$0.00 copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit.



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Covered Service	What you pay
Emergency Care (continued) 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.	
Everyday Options Allowance - Supplemental This benefit provides a combined spending allowance of \$110 every month on your Benefits Prepaid Card. This spending allowance can be used to pay for: - Assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more - OTC products like vitamins, first aid supplies, pain-relievers, and more If you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), you may also be able to use this allowance on: - Healthy Foods like fresh meats, seafood, fruits, vegetables, dairy products, pantry staples, and more - Utilities including gas for your home, electric, water, cable, internet, or cell phone services The Benefits Prepaid Card is automatically loaded at the beginning of each month. Unused amounts expire at the end of each month. The card cannot be used to set up automated recurring transactions. You have a variety of convenient ways to use your benefit: - Shop in-store at participating retailers near you (OTC and Healthy Foods only) - Shop online on the approved vendor website - Shop on the approved vendor mobile app This benefit is continued on the next page	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-Network: \$0.00 copay for Everyday Options Allowance.



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Covered Service	What you pay
Everyday Options Allowance - Supplemental (continued) • Call to place an order • Order by mail (Assistive Devices and OTC only) • With your utility provider Note: • Upon enrollment, you will receive a mailer: - o Including further detail on how to use your benefits and your Benefits Prepaid Card - o Outlining products available for purchase (OTC and Assistive Devices only) • Orders for OTC products and Healthy Foods must be placed through the plan's approved vendor or purchased at a participating retail store. Specific name brands may not be available and quantities may be limited or restricted. Minimum order quantities and delivery fees may apply for online/delivery orders. Not all products are available for delivery. See ordering site for details. • Assistive devices are limited to those offered by the approved vendor and subject to availability. Quantity limits may apply. Installation services are not included. Any repair or replacement is limited to the manufacturer's warranty. • Once you reach your monthly spending allowance, you are responsible for the remaining cost of your purchases. • You may not use this card to purchase items such as gift cards, tobacco or alcohol. Some items such as candy, sodas, certain snack foods and prepared desserts are also excluded. • You can only pay for your own items or services and cannot convert the card to cash. • Some utility providers/merchants may charge processing fees for online or credit card payments. If your Benefits Prepaid Card is not accepted for payment or in the event of a card transaction failure, you may submit a This benefit is continued on the next page	



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Covered Service	What you pay
Everyday Options Allowance - Supplemental (continued) reimbursement request along with proof of payment. Contact information is listed on the back of your Benefits Prepaid Card. A reimbursement request must be submitted within 90 days of the date of payment on your receipt.	
Family planning services The law lets you choose any provider – whether a network provider or out-of-network 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) • limited fertility services such as counseling and education about fertility awareness techniques, and/or preconception health 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 over 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: This benefit is continued on the next page	\$0



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Covered Service	What you pay
Family planning services (continued) • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	
 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	\$0
 Health and wellness education programs - Supplemental These programs are designed to enrich the health and lifestyles of members. • 24/7 Nurseline: As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. - see 24/7 Nurseline for more details • SilverSneakers® Fitness Program - see SilverSneakers® for more details	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for health and wellness programs covered by this plan.
Healthy Meals - Chronic Condition If you have a qualifying chronic condition and meet clinical criteria, you may be eligible for a meals program to assist you in maintaining a healthy diet to support your medical condition or nutritional needs. This benefit is continued on the next page	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Healthy Meals - Chronic Condition (continued) Your meals must be ordered or approved by a healthcare provider and you must be a part of a supervised program designed to transition you to a healthier lifestyle. You, or your provider, can contact Member Services and a representative will help with the process to validate that you qualify for the benefit. If you qualify, you may be contacted to complete a nutritional assessment and schedule delivery of your meals. In order for us to provide your meals benefit, we, or an approved vendor acting on our behalf, may contact you using the phone number you provided to confirm shipping details and any nutritional requirements. A portion of this benefit may be used to obtain meal replacement shakes. Note: We are unable to initiate your benefit without speaking to you. By requesting this benefit, you are authorizing us to contact you by telephone.	In-network: \$0.00 copay for up to 3 meals a day for 14 days to support your chronic condition nutritional needs.
Healthy Meals - Post-discharge - Supplemental After you are discharged from an inpatient stay at a hospital or skilled nursing facility, you may qualify for nutritious, precooked, meals delivered to you at no cost. 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/case manager can contact Member Services after your discharge and a representative will help with the process to 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 an approved vendor acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements. A portion of this benefit may be used to obtain meal replacement shakes.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for up to 2 meals a day for 7 days (maximum 14 meals) following your discharge from the hospital or skilled nursing facility (SNF)



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Covered Service	What you pay
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We also pay for hearing aids when prescribed by a physician or other qualified provider, including: • molds, supplies, and inserts • repairs • an initial set of batteries • six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid • trial period rental of hearing aids • assistive listening devices, surface-worn bone conduction hearing devices • hearing aid-related audiology and post-evaluation services For in-network Medicare-covered hearing care, you must use a doctor in the Anthem Full Dual Advantage Aligned (HMO D-SNP) specialty medical network. You can find them in the Provider/Pharmacy Directory. To learn more, call the Member Services number on the back cover of this booklet. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines. Please contact your care coordinator for details. <i>Prior authorization and referral may be required.</i>	\$0
Hearing services - Supplemental This plan provides additional hearing coverage not covered by Original Medicare. This plan covers 1 routine hearing exam every year. \$300.00 maximum plan benefit for over-the-counter hearing aids OR 1 routine hearing aid fitting evaluation and a This benefit is continued on the next page	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network:



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Covered Service	What you pay
Hearing services - Supplemental (continued) \$3,000.00 maximum plan benefit for prescribed hearing aids every year. Limit up to one pair of hearing aid(s) per year, regardless of type. Over-the-Counter (OTC) hearing aids are only sold in pairs and the benefit maximum is applied to the pair. The plan has negotiated rates and options through our hearing aid vendor to give you the most options. For your hearing aid to be covered, you must select a device from the covered list available through our approved vendor. Hearing aids obtained through an unauthorized vendor are not covered. The approved vendor will send your prescription hearing aids directly to your audiologist and OTC hearing aids directly to you. Prescribed hearing aids may require prior authorization from our hearing vendor to ensure you are fitted with the most appropriate device available under the plan. If you choose a device with non-rechargeable batteries, the plan will provide a 2-year supply (up to 64 cells per hearing aid per year) for prescription hearing aids and a 6-month supply (up to 32 cells per hearing aid per year) for OTC hearing aids. After plan paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost. <i>Prior authorization and referral may be required.</i>	\$0.00 copay for routine hearing exam(s). \$0.00 copay for hearing aids up to the maximum plan benefit amount. Hearing aids are limited to specific devices based on your hearing needs.
 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. If you're 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



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Covered Service	What you pay
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. You must be homebound, which means leaving home is a major effort. 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 <i>Prior Authorization and referral may be required.</i>	\$0
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 aren't 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; This benefit is continued on the next page	\$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.



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Covered Service	What you pay
Home infusion therapy (continued) - remote monitoring; and - monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. <i>Prior authorization and referral may be required.</i>	
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. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: - drugs to treat symptoms and pain - short-term respite care - home care For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare: - Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. For services covered by our plan but not covered by Medicare Part A or Medicare Part B: - Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not This benefit is continued on the next page	\$0



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Covered Service	What you pay
Hospice care (continued) 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 this <i>Member Handbook</i>. When you're admitted to a hospice, you have the right to stay in our plan. Note: If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section below for more information. Note: If you need non-hospice care, call your care coordinator and/or Member Services to arrange the services. Non-hospice care is care that isn't related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who hasn't chosen the hospice benefit. <i>Prior authorization and referral may be required.</i>	
 Immunizations We pay for the following services: • pneumonia vaccines • flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary • hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you at high or intermediate risk of getting hepatitis B • COVID-19 vaccines This benefit is continued on the next page	\$0



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Covered Service	What you pay
 Immunizations (continued) - human papillomavirus (HPV) vaccine - other vaccines if you're at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to Chapter 6 of this <i>Member Handbook</i> to learn more. We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. - A benefit period starts on the first day you go into a hospital or skilled nursing facility. - The benefit period ends when you haven't had any inpatient hospital care or skilled care in a SNF for 60 days in a row. This plan covers 90 days each benefit period. - This plan pays for 60 extra days over your lifetime. You have no copay for these extra days. - The hospital should tell the plan within one business day of any emergency admission. - If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Additional services may be covered in accordance with your Medi-Cal benefits and guidelines; however, this plan covers the Medicare limit of 90 days per benefit period and 60 extra Lifetime Reserve days over your lifetime. 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.



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Covered Service	What you pay
Inpatient hospital care (continued) 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 • 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're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. This benefit is continued on the next page	



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Covered Service	What you pay
Inpatient hospital care (continued) The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive treatment/ services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Member Services. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please go to Chapter 7 of this <i>Member Handbook</i>. • blood, including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. • physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay This benefit is continued on the next page	



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Covered Service	What you pay
Inpatient hospital care (continued) in the hospital overnight, you might still be considered an “outpatient.” If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i>. This fact sheet is available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. <i>Prior authorization may be required.</i>	
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 doesn't apply to inpatient mental health services provided in a psychiatric unit of a general hospital - If you're 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD). <i>Prior authorization may be required.</i>	\$0
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. This benefit is continued on the next page	\$0



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Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) 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 • 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: - o an internal body organ (including contiguous tissue), or - o 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 <i>Prior authorization may be required.</i>	
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. This benefit is continued on the next page	\$0



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Covered Service	What you pay
Kidney disease services and supplies (continued) • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of this <i>Member Handbook</i>, 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. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart. <i>Referral may be required.</i>	
 Lung cancer screening with low dose computed tomography (LDCT) 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 one 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. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	\$0



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Covered Service	What you pay
 Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year 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 order. 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 Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. 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
Medicare Part B 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 • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) This benefit is continued on the next page	\$0



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Covered Service	What you pay
Medicare Part B drugs (continued) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug, Leqembi® (generic lecanemab), which is given intravenously (IV) . In addition to medication costs, you may need additional scans and tests before and/or during treatment. Talk to your doctor about what scans and tests you may need as part of your treatment. • clotting factors you give yourself by injection if you have hemophilia • transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B doesn't cover them • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't inject the drug yourself • some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug). As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug This benefit is continued on the next page	



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Covered Service	What you pay
Medicare Part B drugs (continued) • certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epotin beta) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) 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. The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: https://shop.anthem.com/medicare/ca. Enter your zip code and select Plan Documents. Then click Prescription Drug Coverage Details and choose Part B Step Therapy from the list. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. Chapter 5 of this <i>Member Handbook</i> explains our drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 of this <i>Member Handbook</i> explains what you pay for your drugs through our plan. <i>Prior authorization may be required.</i>	



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Covered Service	What you pay
24/7 Nurseline - Supplemental As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the 24/7 Nurseline at 1-855-658-9249. TTY users should call 711.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0 copay for the 24/7 Nurseline.
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Services that we pay for include, but aren't 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 This benefit is continued on the next page	\$0



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Covered Service	What you pay
Nursing facility care (continued) • durable medical equipment • dental services, including dentures • vision benefits • 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 facility 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
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling This benefit is continued on the next page	\$0



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Covered Service	What you pay
Opioid treatment program (OTP) services (continued) - individual and group therapy - testing for drugs or chemicals in your body (toxicology testing) <i>Prior authorization and referral may be required.</i>	
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 - diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical condition - other outpatient diagnostic tests <i>Prior authorization and referral may be required.</i>	\$0
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. The services must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. This benefit is continued on the next page	\$0



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Covered Service	What you pay
Outpatient hospital observation (continued) Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. <i>Prior authorization and referral may be required.</i>	
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 • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some drugs and biologicals that you can't give yourself <i>Prior authorization and referral may be required.</i>	\$0
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 (CSW) • a clinical nurse specialist (CNS) This benefit continues on the next page.	\$0



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Covered Service	What you pay
Outpatient mental health care (continued) • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • 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 <i>Prior authorization and referral may be required for some services, but they are not required for an initial mental health assessment.</i>	
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. <i>Prior authorization and referral may be required.</i>	\$0



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Covered Service	What you pay
Outpatient substance use disorder 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 <i>Prior authorization and referral may be required for some services, but they are not required for an initial mental health assessment.</i>	\$0
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Note: If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient. Even if you stay in the hospital overnight, you might still be considered an outpatient. <i>Prior authorization and referral may be required.</i>	\$0
Palliative Care Palliative care is covered by our plan. Palliative care is for people with serious illness. It provides patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative Care isn't hospice, therefore you don't have to have a life expectancy of six months or less to qualify for palliative care. Palliative care is provided at the same time as curative/regular care. This benefit is continued on the next page	\$0



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Covered Service	What you pay
Palliative Care (continued) Palliative care includes the following: • advance care planning • palliative care assessment and consultation • a plan of care including all authorized palliative and curative care, including mental health and medical social services • services from your designated care team • care coordination • pain and symptom management You may not get hospice care and palliative care at the same time if you're over the age of 21. If you're getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.	
Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service. <i>Prior authorization may be required for some services, but it is not required for an initial mental health assessment.</i>	\$0



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Covered Service	What you pay
Personal Emergency Response System (PERS) - Supplemental 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 device.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for one personal emergency response system and monthly monitoring by a contracted vendor.
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: - physician's office - certified ambulatory surgical center - hospital outpatient department - any other location - 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 Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with the primary care, individual sessions for mental health visits or individual sessions for psychiatric services. - You have the option of getting these services through an in-person visit or by telehealth. If you choose to get This benefit is continued on the next page	\$0



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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) 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 regardless of your location • telehealth services for diagnosis, evaluation, and treatment of mental health disorders • 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 five-ten minutes if ○ you're not a new patient and ○ the check-in isn't related to an office visit in the past seven 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 seven days and This benefit is continued on the next page	



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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) - 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 <i>Prior authorization and referral may be required for some services, but they are not required for an initial mental health assessment.</i>	
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 <i>Prior authorization and referral may be required.</i>	\$0
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. - Unlimited routine foot care visits each year. <i>Prior authorization and referral may be required.</i>	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for each routine foot care visit.
 Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Pre-exposure prophylaxis (PrEP) for HIV prevention (continued) cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication including the fee for injecting the drug, if applicable. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. • A one-time hepatitis B virus screening.	
 Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	\$0
Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but aren't limited to: • testing, fitting, or training in the use of prosthetic and orthotic devices • 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 This benefit is continued on the next page	\$0



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Covered Service	What you pay
Prosthetic and orthotic devices and related supplies (continued) • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) • prostheses to replace all or 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 and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details. <i>Prior authorization may be required.</i>	
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 an order for pulmonary rehabilitation from the doctor or provider treating the COPD. <i>Prior authorization may be required.</i>	\$0
 Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You’re at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren’t considered high risk, we pay for a screening once. If you’re at high risk (for example, This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Screening for Hepatitis C Virus infection (continued) you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
 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
SilverSneakers – Supplemental SilverSneakers® Membership SilverSneakers® can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations¹. You have access to a nationwide network of participating locations where you can take classes² and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks, and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos, and the SilverSneakers GO mobile app. All you need to get started is your personal This benefit continues on the next page.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0.00 copay for the SilverSneakers® Fitness Program.



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Covered Service	What you pay
SilverSneakers – Supplemental (continued) SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. ¹ Participating location (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. ² Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is not a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. SilverSneakers is a registered trademarks of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to Chapter 12. We pay for the following services, and maybe other services not listed here: • when medically necessary, a minimum 180-day stay • a semi-private room, or a private room if it's medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy This benefit is continued on the next page	\$0



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Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • 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 SNFs • lab tests given by SNFs • 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 SNF care from network facilities. Under certain conditions, 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 facility 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 <i>Prior authorization may be required.</i>	
 Smoking and tobacco use cessation Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling This benefit is continued on the next page	\$0



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Covered Service	What you pay
 Smoking and tobacco use cessation (continued) We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year).	
Special Supplemental Benefits for the Chronically Ill The following benefit(s) are Special Supplemental Benefits for the Chronically Ill and available to all members who meet the CMS criteria in Section C of this chapter. Everyday Options Allowance: The following benefits are part of the Everyday Options Allowance. • Healthy Foods* • Utilities*	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-network: \$0 copay for Special Supplemental Benefits for the Chronically Ill. *Please refer to the Everyday Options Allowance section in this chart for more information.
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) This benefit is continued on the next page	\$0



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Covered Service	What you pay
Supervised exercise therapy (SET) (continued) • 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 (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques <i>Prior authorization may be required.</i>	
Transportation: Non-emergency medical transportation This benefit allows for medical transportation for a service covered by our plan and Medicare. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with paratransit. The forms of transportation are authorized when: • Your medical provider determines your medical and/or physical condition doesn't allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and prior authorization is required and you'll need to call your plan to arrange a ride. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. <i>Prior authorization may be required.</i>	\$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 covered by Medi-Cal, including travel to dental	\$0



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Covered Service	What you pay
Transportation: Non-medical transportation (continued) appointments and to pick up drugs. Transportation for services dually covered by Medi-Cal and Medicare are covered. See the Transportation – Supplemental category below for information on how to obtain supplemental transportation services.	
Transportation - Supplemental This benefit covers routine, non-emergency one-way trips (60-mile limit per one-way trip) to locations within the local service area when obtaining plan-approved health-related services. Trips may be covered for getting to and from plan-approved medical-related visits, fitness centers, and visits to a pharmacy to pick up prescriptions. You can use this benefit for one-way trips or you can schedule a round trip by using two one-way trips. Short stops at a pharmacy to pick up a prescription after a plan-approved medical-related visit can be made as part of the return trip and will not require a separate trip. Ask the provider/facility to call in the prescription so you have a shorter wait. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. Modes of approved transportation may include: • Taxi • Rideshare • Wheelchair Van • Public Transportation You must use the plan-approved vendor and schedule trips at least 48 hours (excluding weekends) in advance. Please refer to the Ambulance Services section in this chart for information on non-emergency Medicare-covered ambulance services.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. In-Network: \$0.00 copay. This plan offers coverage for 96, one-way, routine transportation services every year. Trips are limited to 60 miles.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Covered Service	What you pay
Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, or • an unforeseen illness, or • an injury, or • a condition that needs care right away. If you require urgently needed 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 because given your time, place, or circumstances, it's not possible, or it's unreasonable, to get this service from network providers (for example, when you're outside the plan's service area and you require medically needed immediate services for an unseen condition but it's not a medical emergency). Urgently needed service coverage is worldwide. This plan covers worldwide urgent care 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 urgent care and 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 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, seven days a week, 365 days a year.	\$0.00 copay for each covered urgently needed service. \$0.00 copay for each covered worldwide urgently needed service.
Video Doctor Visits - Supplemental 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. This benefit is continued on the next page	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Video Doctor Visits - Supplemental (continued) 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 needed¹. - 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 talk with a therapist² or make an appointment and talk with a psychiatrist³ from the privacy of your home. 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 offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan. ¹Prescription is prescribed based on physician recommendations and state regulations (rules). ²Appointments are typically scheduled within seven days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. This benefit is continued on the next page	In-network: \$0.00 copay for video doctor visits using LiveHealth Online.



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Covered Service	What you pay
Video Doctor Visits - Supplemental (continued) ³Appointments are typically scheduled within 28 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	
 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, 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 50 and over • Hispanic Americans who are 65 and over For people with diabetes, we pay for screening for diabetic retinopathy once per year. 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 can't get two pairs of glasses after the second surgery, even if you didn't get a pair of glasses after the first surgery.	\$0
Vision Care - Supplemental The plan provides additional vision coverage not covered by Original Medicare. This plan covers 1 routine eye exam(s) every year.	Any costs you pay for Medicare Non-covered Services will not count
This benefit is continued on the next page.	



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Covered Service	What you pay
Vision Care - Supplemental (continued) This plan covers up to \$400.00 for eyeglasses or contact lenses every year.	toward your maximum out-of-pocket amount. In-network: \$0.00 copay for one routine eye exam every plan year. Refractions are covered as part of a routine eye exam and are not covered if billed separately. \$0.00 copay for eyewear up to the allowance amount every plan year. The amount the plan covers for eyewear is deducted from the total charged amount billed to insurance. After plan paid benefits for eyewear are applied, you are responsible for any remaining costs including non-covered services. Benefits available under this plan cannot be combined with any other in-store discounts.
 “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 preventive services you need (including screenings and shots (or vaccines)), and	\$0
This benefit continues on the next page.	



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Covered Service	What you pay
 “Welcome to Medicare” preventive visit 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.	

Dental services – Supplemental limitations and exclusions

Our plan partners with a dental vendor to provide your dental benefits.

Please note: Crown services, retainer crowns, and pontics require clinical review for prior authorization before treatment is performed to determine if they are appropriate and meet industry standards, clinical criteria, and guidelines. Treatment requests which are not medically necessary or do not meet clinical criteria and guidelines will not be covered. If prior authorization is denied, the service will not be covered and you will be responsible for all associated costs.

To locate a network provider or for questions related to our dental vendor plan’s clinical guidelines, you may call dental vendor’s Member Services or search the dental vendor’s website. It is recommended you work with your in-network dentist to check benefit coverage prior to obtaining dental services. Services performed by an out-of-network provider are only covered if listed in the Dental services – Supplemental section of the **Chapter 4** Medical Benefits Chart.

Coverage is limited to the services listed in the Dental services – Supplemental section of the **Chapter 4** Medical Benefits Chart with the following additional limitations and exclusions:

The following dental services require prior authorization:

Cone Beam CT (CBCT): Cone Beam CT is a special type of X-ray used when regular dental X-rays do not show enough detail. **Prior authorization is required.**

It may be covered if:

- You have pain or problems that normal X-rays can't explain.
- Your tooth has extra or hidden roots.
- You had a root canal before and need another one.
- There's a risk of nerve damage or a broken jaw.



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- You're getting an implant and it's a covered service.

Crown Services: These services place a cap that covers a damaged tooth to protect it and help it work like a normal tooth again. **Prior authorization is required.**

Crowns may be covered if:

- The tooth is mostly broken or has a large cavity.
- There is a big crack or part of the tooth is missing.
- An old crown is damaged or has decay under it.
- The tooth is still used to chew.
- A front tooth is broken and can't be fixed with a filling.

Crowns are not covered if:

- The tooth is just worn down over time.
- You want it only to change how the tooth looks (like for color or shape).

Crowns should be placed after other needed treatments like root canals or gum work.

1. Requires prior authorization through the dental vendor.
2. Requests for crowns require the tooth/teeth to have a good long-term restorative, endodontic, and periodontal (at least 50% bone support) prognosis for approval.
3. Requests for crowns on teeth without root canal treatment must show evidence of decay, fracture, failing restoration, etc., undermining more than 50% of the tooth to be considered for coverage.
4. Replacement of existing crowns which, in the opinion of the dental vendor's staff dentist or dental director is satisfactory or can be made to a satisfactory condition, is not covered.
5. Cosmetic or experimental dental services and/or procedures not generally performed in a general dentist's office are not covered.
6. Crowns for the purposes of esthetics, or as a result of normal wear & attrition, recession, abfraction and/or abrasion are not covered.
7. Core Buildup, including any pins when required (CDT Code D2950), must show evidence that the tooth requires additional structure critical to support and retain a crown or bridge. Otherwise, the service will be considered included as part of the crown restoration.
8. Providers must submit all necessary documents to prove the services meet plan criteria and are medically necessary. This includes full mouth X-rays and treatment plan. Missing documents will lead to a denial of services. Services lacking enough documentation to show necessity, according to the dental vendor's criteria, will be denied.



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Core Buildup (Building Up a Tooth): This helps rebuild a broken tooth so a crown can stay on. **Prior authorization is required.**

It may be covered if:

- The tooth doesn't have enough left to hold a crown.

It is not covered if:

- It's just filling a small hole.
- It's only to make the tooth a better shape.

Post and Core: This is used after a root canal to help hold a crown in place and support the crown. **Prior authorization is required.**

It may be covered if:

- The tooth had a root canal.

Root Canals (Endodontic Treatment): Prior authorization is required.

Root canals may be covered if:

- The dentist finds the nerve is damaged or infected.
- The tooth is important to keep.
- The tooth can be fixed and last at least 5 years.
- The dentist can show why a root canal is needed (like with X-rays and notes).

Bone Grafting for Teeth: Prior authorization is required.

Bone grafting may be covered if:

- The bone around a tooth is damaged by disease.
- It is done to help save the tooth and rebuild bone.

It is not covered if:

- It's done at the same time as pulling the tooth.
- It's only for getting ready for an implant (unless implants are covered).

Bone Graft After Tooth Pulling (Ridge Preservation): This helps keep the bone shape after a tooth is pulled. **Prior authorization is required.**

It may be covered if:

- You're planning to get an implant there.



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- The dentist explains why it's needed to improve your health.

Gum Surgery to Rebuild Bone: Special materials may be used during gum surgery to help rebuild bone. **Prior authorization is required.**

It is covered only if:

- The bone loss is around natural teeth.
- It's part of a treatment to save the tooth.

It is not covered for implants.

Complex Tooth Extractions (Pulling Teeth): Prior authorization is required.

Tooth removal may be covered if:

- The tooth is very decayed or infected.
- There's gum disease that can't be fixed.
- The tooth is causing pain or other big problems.
- A baby tooth won't fall out soon and is hurting.

Tooth pulling is not covered if:

- It's just to stop future crowding.
- There is no real problem shown on X-rays.

Alveoloplasty (Bone Smoothing for Dentures): This is bone reshaping before getting dentures. **Prior authorization is required.**

It may be covered if:

- You are getting full dentures.
- The dentist explains why this is needed.

Small bone smoothing done during tooth pulling or implant placement is included in those services.

Crown Lengthening (Showing More Tooth): This surgery removes gum and bone so more of the tooth shows above the gum. **Prior authorization is required.**

It may be covered if:

- There's not enough tooth showing to hold a crown.
- The bone needs to be reshaped to fit the crown properly.



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Retainer Pontics and Crowns (Bridges for Missing Teeth): A fixed partial denture is also called a bridge. Bridges require prior authorization.

Requests for bridges require a missing tooth in the arch with at least one strong tooth on each side and enough space for a replacement tooth. If a removable denture can fix your teeth look and work, a bridge may not be covered. Bridges are generally not covered when you are missing teeth on both side of your mouth unless:

- You have a medical reason you cannot wear a removable denture, and
- Your denture records show that a removable denture did not work for you.

Requests for bridges require the supporting teeth to have a good long-term restorative, endodontic, and periodontal (at least 50% bone support) prognosis for approval. They should last at least 5 years. Bridges are not covered if you have untreated gum disease or if the supporting teeth are not strong enough.

Requests for a “cantilevered pontic” or only one supporting tooth next to a missing tooth will not be covered for the replacement of a missing back tooth. In some cases, it may be allowed for a missing upper side front tooth if the nearby tooth is strong. Bridges may be considered for front teeth because they do not take as much pressure when you bite. This may include:

- One missing upper front tooth, or
- Two missing lower front teeth next to each other

Requests for bridges must be between teeth that are alike. Bridges with a fake tooth, such as an implant, on one side and a natural tooth on the other side will not be covered. Wisdom teeth are not usually replaced unless they are needed for chewing.

Replacement of an existing bridge is not covered which, in the opinion of the dental vendor’s staff dentist or dental director, is satisfactory or that can be repaired. If replacement is requested, your dentist must submit documentation showing why the bridge cannot be repaired. This documentation must include a treatment plan and current dental X-rays or other supporting records, such as photographs, that show damage, decay, gaps, or other conditions supporting the need for replacement. The dental vendor may request additional information before making a coverage decision.

Cosmetic or experimental dental services and/or procedures not generally performed in a general dentist’s office are not covered.

Core Buildup, including any pins when required (CDT Code D2950), must show evidence that the tooth requires additional structure critical to support and retain a crown or bridge. Otherwise, the service will be considered included as part of the crown restoration.

Providers must submit all necessary documents to prove the services meet plan criteria and are medically necessary. This includes a treatment plan and full mouth X-rays that clearly show the condition of the tooth or teeth, including decay, damage, bone loss or gaps. A dental reviewer may ask for more information about your treatment plan. Missing documents will lead to a denial of services.



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Services lacking enough documentation to show necessity, according to the dental vendor's criteria, will be denied.

Providers must use correct billing codes for bridges. Codes for single crowns cannot be used instead.

Other Limitations and Exclusions:

- Providers must submit all necessary documents to prove the service meets the plan's criteria and is medically necessary. This includes full mouth X-rays and a treatment plan. Missing documents will lead to a denial of service. Services lacking enough documentation to show necessity, according to the dental vendor's criteria, will be denied.
- Any procedure not specifically listed as a covered benefit in the Dental services - Supplemental section of the **Chapter 4** Medical Benefits Chart is not covered.
- Services related to a denied service will also be denied.
- Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.
- Treatment is not covered if it's due to civil insurrection, military service, acts of war, or nuclear incidents.
- Services for injuries and/or conditions which are paid or payable under Worker's Compensation or Employer Liability Laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
- Fees for missed appointments, preparing or copying dental reports, duplicate X-rays, itemized bills, or claim forms are not covered.

The dental vendor's criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

Dental procedure codes and descriptions provided are based on CDT codes guidelines and intended for information purposes only. These codes can change annually according to the updates released by the American Dental Association's Current Dental Terminology (CDT). These updates may introduce new codes, alter existing ones, or eliminate others. We recommend that you confirm the relevant procedure codes with our contracted dental vendor and dental provider before undergoing treatment to ensure they have the latest and most accurate information. The organization assumes no liability for claims denied due to the use of outdated or incorrect codes.

For more information about covered dental procedure codes, log into www.anthem.com/ca and visit plan documents section.



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E. Community Supports

You may get supports under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members. If you qualify, these services may help you live more independently. They don't replace benefits that you already receive under Medi-Cal.

Examples of community supports that we offer include:

- **Community transition to a home:** For members living in a Nursing Facility (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 NF level of care
- **Medically tailored meals or medically supportive food:** Up to two meals a day or vouchers for healthy food for members who have a clinical need for a 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
- **Respite:** For members with informal caregivers who are at risk of being unable to provide informal care without a break



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- **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 1-833-897-1342 (TTY 711) or call your health care provider.

F. Benefits covered outside of our plan

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

F1. 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 60 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.



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F2. Medi-Cal Dental

Certain dental services are available through Medi-Cal Dental. More information is on the [SmileCalifornia.org](https://smilecalifornia.org) website. Medi-Cal Dental includes but is not limited to, services such as:

- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

For more information regarding dental benefits available in Medi-Cal Dental, or if you need help finding a dentist who accepts Medi-Cal, contact the Member Services line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental 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 smilecalifornia.org/ for more information.

In Sacramento and Los Angeles counties, you may get Medi-Cal dental benefits through a Dental Managed Care (DMC) plan. If you want more information about Medi-Cal dental plans or want to make changes, 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. DMC contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

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

F3. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.
- Your care coordinator can help you apply for IHSS with your county social service agency. To learn more about IHSS available in your county, go to <https://www.cass.ca.gov/inforesources/ihss>. Or call your local county social services agency.



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F4. 1915(c) Home and Community Based Services (HCBS) Waiver Programs

Assisted Living Waiver (ALW)

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- The ALW is currently only available in the following counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, and Sonoma.
- Your care coordinator can help you apply for the ALW. To learn more about the ALW Waiver, go to <https://www.dhcs.ca.gov/services/ltc/Pages/AssistedLivingWaiver.aspx> or call 1-833-897-1342.

HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)

California Self-Determination Program (SDP) Waiver for Individuals with Developmental Disabilities

- There are two 1915(c) waivers, the HCBS-DD Waiver and SDP Waiver, that provide services to people who have been diagnosed with a developmental disability that begins before the individual's 18th birthday and is expected to continue indefinitely. Both waivers are a way to fund certain services that allow persons with developmental disabilities to live at home or in the community rather than residing in a licensed health facility. Costs for these services are funded jointly by the federal government's Medicaid program and the State of California. Your care coordinator can help connect you to DD Waiver services.

Home and Community-Based Alternative (HCBA) Waiver

- The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team comprised of a nurse and social worker. The team coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.



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- Members who are enrolled in the HCBA Waiver can remain enrolled in the HCBA Waiver while also receiving benefits provided by our plan. Our plan works with your HCBA waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the HCBA. To learn more about the HCBA Waiver go to <https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-%28HCB%29-Alternatives-Waiver.aspx> or call 1-833-897-1342.

Medi-Cal Waiver Program (MCWP)

- The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs to keep the participant in their home and community.
- The goals of the MCWP are to: (1) provide home and community-based services for persons with HIV who may otherwise require institutional services; (2) assist participants with HIV health management; (3) improve access to social and behavioral health support and (4) coordinate service providers and eliminate duplication of services.
- Members who are enrolled in the MCWP Waiver can remain enrolled in the MCWP Waiver while also receiving benefits provided by our plan. Our plan works with your MCWP waiver agency to coordinate the services you receive.
- Your care coordinator can help you apply for the MCWP. To learn more about the MCWP Waiver go to <https://www.dhcs.ca.gov/services/ltc/Pages/AIDS.aspx> or call 1-833-897-1342.

Multipurpose Senior Services Program (MSSP)

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals remain in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that aren't otherwise available to prevent or delay institutionalization. The total annual combined cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.
- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
 - o care management



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- o adult day care
- o minor home repair/maintenance
- o supplemental in-home chore, personal care, and protective supervision services
- o respite services
- o transportation services
- o counseling and therapeutic services
- o meal services
- o communication services.
- Members who are enrolled in the MSSP Waiver can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive.
- Your care coordinator can help you apply for MSSP. To learn more about the MSSP Waiver, go to <https://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx> or call 1-833-897-1342.

F5. County Behavioral Health Services Provided Outside Our Plan (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 and Medi-Cal managed care. Our plan does not provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through county behavioral health agencies.

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 your county MHP include:

- mental health services
- medication support services
 - o day treatment intensive services
- day rehabilitation
 - o crisis intervention services
 - o crisis stabilization services
- adult residential treatment services
- crisis residential treatment services



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- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services

Drug Medi-Cal (DMC) services are available to you through your county behavioral health agency if you meet criteria to receive these services.

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)

Drug Medi-Cal Organized Delivery System (DMC-ODS) Services include:

- outpatient treatment services
- intensive outpatient treatment services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- inpatient treatment services

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

The Los Angeles County Department of Mental Health offers evaluation, assessment and treatment to determine the criteria that meets medical necessity and best meets members needs.

The health plan provides care coordination by:

- Helping educate you and providers about Medi-Cal benefits and services, helping you obtain these services and referrals to the county for provision of services and/or follow up.
- When a member is referred for mental health services and is identified as having an alcohol or drug use diagnosis that is referred and/or treated by Drug Medi-Cal, the Plan's Care Coordinator



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will follow best practice guidelines in obtaining appropriate consent and coordinating care between PCP and Drug Medi-Cal providers.

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

This section tells you about benefits excluded by our plan. “Excluded” means that we don't pay for these benefits. Medicare and Medi-Cal don't pay 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 don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

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

- services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal, unless listed 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 this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren't 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's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it



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- 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
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures
- 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'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.
- custodial care, which includes personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living like bathing and dressing
- providers who are prohibited from being covered under the Medicare program for any reason
- prescription drugs you buy outside the U.S.
- items and services administered to a beneficiary for the purpose of causing or assisting in causing death
- items and services required as a result of war
- defective equipment or medical devices covered under warranty.



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Chapter 5: Getting your outpatient drugs

Introduction

This chapter explains rules for getting your outpatient 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 this *Member Handbook*.

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you're 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're 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 this *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you're in Medicare hospice. For more information, please refer to **Chapter 5, Section F** "In a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

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

You must have a provider (doctor, dentist, or other prescriber) 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 PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription. (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter).

- If it isn't 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.

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 (FDA) or supported by certain medical references. Your



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prescriber may be able to help identify medical references to support the requested use of the prescribed drug. A "medically accepted indication" means the drug is being used for a condition that the FDA has approved it for, or that medical experts recognize as safe and effective in trusted medical references.

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter).

Table of Contents

A. Getting your prescriptions filled	133
A1. Filling your prescription at a network pharmacy	133
A2. Using your Member ID Card when you fill a prescription	133
A3. What to do if you change your network pharmacy	133
A4. What to do if your pharmacy leaves the network	133
A5. Using a specialized pharmacy	133
A6. Using mail-order services to get your drugs	134
A7. Getting a long-term supply of drugs	137
A8. Using a pharmacy not in our plan's network	137
A9. Paying you back for a prescription	138
B. Our plan's <i>Drug List</i>	138
B1. Drugs on our <i>Drug List</i>	138
B2. How to find a drug on our <i>Drug List</i>	139
B3. Drugs not on our <i>Drug List</i>	139
B4. <i>Drug List</i> tiers	140
C. Limits on some drugs	140
D. Reasons your drug might not be covered	142
D1. Getting a temporary supply	142
D2. Asking for a temporary supply	143
D3. Asking for an exception	144
E. Coverage changes for your drugs	144
F. Drug coverage in special cases	146
F1. In a hospital or a skilled nursing facility for a stay that our plan covers	146
F2. In a long-term care facility	146
F3. In a Medicare-certified hospice program	146
G. Programs on drug safety and managing drugs	147
G1. Programs to help you use drugs safely	147
G2. Programs to help you manage your drugs	147
G3. Drug management program (DMP) to help members safely use opioid medications	148



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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. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

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

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered drug.

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 Member ID Card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment 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, contact Member Services right away.** We'll do everything we can to help.

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

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, refer to 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:



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- Pharmacies that supply drugs for home infusion therapy.
- Our plan will cover home infusion therapy if:
 - o Your prescription drug is on our plan's formulary, or a formulary exception has been granted for your prescription drug.
 - o Your prescription drug is not otherwise covered under our plan's medical benefit or Medi-Cal RX.
 - o Our plan has approved your prescription for home infusion therapy.
 - o Your prescription is written by an authorized prescriber.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
 - o 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.
 - o If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Indian Health Care Provider (IHCP) Pharmacies. American Indian and Alaska Native Members have access to pharmacies at an Indian Health Care Provider (IHCP) to the extent they have an enrolled retail pharmacy. If you're not American Indian or Alaska Native, you may still receive services from a retail pharmacy at an IHCP if you are assigned to the clinic or for an emergency.
- Pharmacies that dispense drugs 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, refer to 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. Drugs available through our plan's mail-order service are marked as mail-order drugs in our *Drug List*.

Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 100-day supply. A 100-day supply has the same copay as a one-month supply.



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Filling prescriptions by mail

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, 7 days a week.

Usually, a mail-order prescription arrives within 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 and 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 get a prescription automatically by mail that you don't 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 don't want the pharmacy to automatically fill and ship each new prescription, please contact us by calling the Member Services 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 it is shipped.

It's 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 Services 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**



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- 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 the Member Services phone number on your membership card.

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's 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 the Member Services phone number on your membership card.

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. 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.



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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 you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90- or 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.

An extended-day supply may be available in the event of an emergency or declared disaster. Please contact the plan for more details.

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 prescriptions filled as a member of our plan. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

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.)
- You are unable to obtain a covered drug from a network pharmacy due to a declared disaster or emergency.

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



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A9. Paying you back for a prescription

Anthem Full Dual Advantage Aligned (HMO D-SNP) 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 this *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 Part D.

Most of the drugs you get from a pharmacy are covered by our 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, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. 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. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on



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state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

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:

- Visit our plan's website at www.anthem.com/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
- Use our "Real Time Benefit Tool" at www.anthem.com/ca to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call Member Services.

B3. Drugs not on our *Drug List*

We don't cover all 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*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*. For more information refer to **Chapter 9**.

Our plan doesn't pay for the kinds of drugs described 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 this *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D) can't pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren't considered part of your outpatient drug benefits.
2. Our plan can't cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor or other provider may prescribe a certain drug to treat



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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 can't cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms*
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride* preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia, weight loss or weight gain*
- Outpatient drugs made by a company that says you must have tests or services done only by them

*Select products may be covered by Medi-Cal. Please visit the Medi-Cal Rx website (www.medi-calrx.dhcs.ca.gov) for more information.

B4. Drug List tiers

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

- **Tier 1 - Preferred Generic:** Common medication for ongoing conditions.
- **Tier 2 - Generic:** Generic drugs and may include some brand name drugs.
- **Tier 3 - Preferred Brand:** Commonly used brand name drugs and may also include generic drugs.
- **Tier 4 - Non-Preferred Drug:** Brand name and generic drugs.
- **Tier 5 - Specialty Tier:** Drugs for complex or serious conditions.

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

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

C. Limits on some drugs

For certain 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.



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Note that sometimes a drug may appear more than once in our *Drug List*. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

If there's 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 shouldn't apply to your situation, ask us to use the coverage decision process 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 this *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's a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually don't 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 won't work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. This is called prior authorization. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at https://shop.anthem.com/medicare/docs/2026_PRIOR_AUTH_ADV_MAPD.pdf for more information about prior authorization.

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 **doesn't** work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at https://shop.anthem.com/medicare/docs/2026_PARTD_STEP_THERAPY_ADV_MAPD.pdf?v=202506301450 for more information about step therapy.

4. Quantity limits



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, 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 www.anthem.com/ca. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of this *Member Handbook*.

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. 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 isn't 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:

- You were in our plan last year.
 - 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.



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- o 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.
- o Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You're new to our plan.
 - o We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
 - o This temporary supply is for up to 30 days.
 - o 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.
 - o Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.
- You've been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
 - o 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.

D2. Asking for a temporary supply

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 isn't 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

D3. Asking for an exception

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).
- If we approve your request, we'll authorize coverage for the drug before the change takes effect.

To learn more about asking for an exception, refer to **Chapter 9** of this *Member Handbook*.

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

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 authorization 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).
- Replace an original biological product with an interchangeable biosimilar version of the biological product.

We must follow Medicare requirements before we change our plan's *Drug List*. 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 won't 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 isn't safe, **or**
- a drug is removed from the market.

What happens if coverage changes for a drug you are taking?

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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

Changes we may make to the *Drug List* that affect you during the current plan year

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

A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same. 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'll 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'll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this *Member Handbook* for more information on exceptions.

Removing unsafe drugs and other drugs that are off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Your prescriber will also know about this change and can work with you to find another drug for your condition.

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.

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's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

Changes to the *Drug List* that don't affect you during this plan year



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't 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 doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current year. You'll need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan 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're admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your drugs during your stay. You won't 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 facility, has its 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 drugs through the facility's pharmacy if it's 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 isn't 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 certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice doesn't cover because it isn't 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 have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *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 similar 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
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, 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'll 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your prescriber 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.

MTM 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 don't want to be in the program, let us know, and we'll take you out of it.

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

G3. Drug management program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP).

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

- Requiring you to get all prescriptions for those medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we cover for you.

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

Introduction

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

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

Because you're eligible for Medi-Cal, you get Extra Help from Medicare to help pay for your Medicare Part D drugs.

Extra Help is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D 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 this *Member Handbook*.

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

- Our *List of Covered Drugs*.
 - o We call this the “*Drug List*.” It tells you:
 - which drugs we pay for
 - which of the five tiers each drug is in
 - if there are any limits on the drugs
 - o 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 www.anthem.com/ca.
 - o Most of the drugs you get from a pharmacy are covered by Anthem Full Dual Advantage Aligned (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 (med-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 this *Member Handbook*.
 - o Explains how to get your outpatient drugs through our plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- o It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
- o When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you're expected to pay. You can call Member Services for more information.
- Our *Provider and Pharmacy Directory*.
 - o In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
 - o The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* for more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)..... 152

B. How to keep track of your drug costs 153

 B1. What if you find mistakes on this summary? 153

 B2. What about possible fraud? 154

C. You pay nothing for a one-month or long-term supply of drugs..... 154

 C1. Your pharmacy choices 154

 C2. Getting a long-term supply of a drug 154

D. What you pay for Part D vaccines 155

 D1. What you need to know before you get a vaccine..... 155



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We 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. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get drugs through our plan, we send you a summary called the *Explanation of Benefits* (EOB). We call it the EOB for short. The EOB isn't a bill. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **Totals for the year since January 1**. This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information**. This is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- 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 (www.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.
- To find out which drugs our plan covers, refer to our *Drug List*.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

B. How to keep track of your drug costs

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

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

You can ask us to pay you back for the drug. Here are examples of when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't 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 under special circumstances.

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

3. Send us information about payments others make for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the EOBs we send you.

When you get an EOB in the mail, make sure it's complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

B1. What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Anthem Full Dual Advantage Aligned (HMO D-SNP) Member Services.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

B2. What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Anthem Full Dual Advantage Aligned (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free.
- If you suspect that a provider who gets Medi-Cal has committed fraud, waste, or abuse, it's your right to report it by calling the confidential toll-free number 1-800-822-6222. Other methods of reporting Medi-Cal fraud may be found at: www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They're 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 if you follow our rules. If you lose your Medi-Cal eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

C1. Your pharmacy choices

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

- a network pharmacy, **or**
- an out-of-network pharmacy. In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** of this *Member Handbook* to find out when we do that.
- Our plan's mail-order pharmacy.

Refer to **Chapter 9** of the *Member Handbook* 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*.

C2. 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 a 90-day supply. There is no cost for 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 this *Member Handbook* or our *Provider and Pharmacy Directory*.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

D. What you pay for Part D vaccines

Important message about what you pay for vaccines: Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to our plan's *Drug List* or contact Member Services for coverage about specific vaccines.

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

1. The first part is for the cost of **the vaccine itself**.
2. The second part 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 vaccine

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

- We can tell you about how our plan covers your vaccine.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Chapter 7: Asking us to pay a bill you received 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 don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs.....	157
B. Sending us a request for payment.....	160
C. Coverage decisions	161
D. Appeals	161



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A. Asking us to pay for your services or drugs

You shouldn't get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We don't allow Anthem Full Dual Advantage Aligned (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, don't 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'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
 - If you paid for services covered by Medicare, we'll pay you back.
- If you paid for Medi-Cal services you already received, you may qualify to be reimbursed (paid back) if you meet all of the following conditions:
 - The service you received is a Medi-Cal covered service that we're responsible for paying. We won't reimburse you for a service that isn't covered by Anthem Full Dual Advantage Aligned (HMO D-SNP).
 - You received the covered service after you became an eligible Anthem Full Dual Advantage Aligned (HMO D-SNP) member.
 - You ask to be paid back within one year from the date you received the covered service.
 - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
 - You received the covered service from a Medi-Cal enrolled provider in Anthem Full Dual Advantage Aligned (HMO D-SNP)'s network. You don't need to meet this condition if you received emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to provide proof from the provider that shows a medical need for the covered service.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- Anthem Full Dual Advantage Aligned (HMO D-SNP) will tell you if they'll reimburse you in a letter called a Notice of Action. If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, Anthem Full Dual Advantage Aligned (HMO D-SNP) will pay you back for the full amount you paid. We'll reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but isn't in our network and refuses to pay you back, Anthem Full Dual Advantage Aligned (HMO D-SNP) will pay you back, but only up to the amount that FFS Medi-Cal would pay. Anthem Full Dual Advantage Aligned (HMO D-SNP) will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you don't meet one of the above conditions, we won't pay you back.
- We won't pay you back if:
 - You asked for and received services that aren't covered by Medi-Cal, such as cosmetic services.
 - The service isn't a covered service for Anthem Full Dual Advantage Aligned (HMO D-SNP).
 - You went to a doctor who doesn't take Medi-Cal and you signed a form that said you want to be seen anyway and you'll pay for the services yourself.
- If we don't cover the services or drugs, we'll 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.

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

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

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'll pay the provider directly.
 - If you already paid for the Medicare service, we'll pay you back.

2. When a network provider sends you a bill



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Network providers must always bill us. It's important to show your Member ID Card when you receive any services or prescriptions; however, sometimes network providers make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Member Services** at the number at the bottom of this page **if you get any bills**.

- Because we pay the entire cost for your services, you aren't responsible for paying any costs. Providers shouldn't bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We'll contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We'll pay you back for your covered services.

3. If you're retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

4. When you use an out-of-network pharmacy to fill a prescription

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

- In only a few cases, we'll 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 this *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

If you don't have your Member 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 Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

6. When you pay the full Medicare Part D 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 this *Member Handbook*).
 - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of this *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. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

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 this *Member Handbook*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. 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. You must send your information to us within one year of the date you received the service, item or drug.

To make sure you give us all the information we need to decide, 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 www.anthem.com/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:

Payment Request Address
Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Mail your request for payment for **Part D prescription** drugs together with any bills or receipts to this address:

Part D Payment Request Address
CarelonRx
Claims Department - Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

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'll 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'll pay for it. If you already paid for the service or drug, we'll mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

Chapter 3 of this *Member Handbook* explains the rules for getting your services covered.

Chapter 5 of this *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'll 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 this *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**.



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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*.

Table of Contents

A. Your right to get services and information in a way that meets your needs	163
B. Our responsibility for your timely access to covered services and drugs.....	188
C. Our responsibility to protect your personal health information (PHI).....	188
C1. How we protect your PHI.....	189
C2. Your right to look at your medical records.....	190
C3. Notice of Privacy Practices	196
D. Our responsibility to give you information	202
E. Inability of network providers to bill you directly	203
F. Your right to leave our plan	203
G. Your right to make decisions about your health care.....	204
G1. Your right to know your treatment choices and make decisions.....	204
G2. Your right to say what you want to happen if you can't make health care decisions for yourself	204
G3. What to do if your instructions are not followed	205
H. Your right to make complaints and ask us to reconsider our decisions.....	206
H1. What to do about unfair treatment or to get more information about your rights	206
I. Your responsibilities as a plan member	206



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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. 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're 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 including Arabic, Armenian, Cambodian (Khmer), Chinese Simplified, Chinese Traditional, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian and Vietnamese and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services or write to Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- 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.
- Call Member Services at the number listed on the bottom of this page to change or cancel a standing order. You can also find your documents online at www.anthem.com/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.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.
- 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. حقك في الحصول على الخدمات والمعلومات بطريقة تلبي احتياجاتك

نحن ملتزمون بضمان تقديم جميع الخدمات، السريية وغير السريية، بشكل يراعي الثقافة ويسهل الوصول إليه، خصوصاً للأشخاص ذوي الكفاءة المحدودة في اللغة الإنجليزية، أو القراءة، أو ضعف السمع، أو ممن ينتمون إلى خلفيات ثقافية وعرقية متنوعة. يجب أن نخبرك أيضاً عن مزايا خطتنا وحقوقك بطريقة يمكنك فهمها. ويجب علينا إبلاغك بحقوقك كل عام طالما أنك مشترك في خطتنا.

- للحصول على معلومات بطريقة يمكنك فهمها، اتصل بخدمة الأعضاء. لدينا في خطتنا خدمات الترجمة الفورية التي يمكنك الاستعانة بها للحصول على إجابة عن الأسئلة بلغات مختلفة.
- يمكن لخطتنا أن توفر لك مواداً بلغات أخرى غير الإنجليزية، بما في ذلك: العربية، والأرمنية، والكمبودية (الخميرية)، والصينية المبسطة، الصينية التقليدية، والفارسية، والهندية، والهمونغ، واليابانية، والكورية، واللاوية، والميان، والبنجابية، والروسية، والإسبانية، والتاغالوغية، والتايلاندية، والأوكرانية، والفيتنامية، وكذلك بصيغ مثل: الخط الكبير، أو برايل، أو المواد الصوتية. للحصول على مواد بأحد هذه الصيغ البديلة، يُرجى الاتصال بخدمة الأعضاء أو الكتابة إلى Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- يمكنك الحصول على هذا المستند مجاناً بلغات وتنسيقات أخرى كأن تكون مطبوعةً بأحرف كبيرة أو بطريقة برايل أو مسجلة صوتياً. اتصل بخدمة الأعضاء على الرقم المذكور في أسفل هذه الصفحة. عند الاتصال، أخبرنا إذا كنت تريد أن يكون ذلك طلباً ثابتاً. ويعني ذلك أننا سنرسل نفس المستندات بالتنسيق المطلوب واللغة المطلوبة من جانبك كل عام.
- اتصل بخدمة الأعضاء على الرقم المذكور في أسفل هذه الصفحة لتغيير أمر دائم أو إلغائه. يمكنك أيضاً العثور على مستنداتك عبر الإنترنت على الموقع www.anthem.com/ca.

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

- Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. يمكنك الاتصال على مدار 24 ساعة وطوال 7 أيام في الأسبوع. ويجب على مستخدمي TTY الاتصال على الرقم 1-877-486-2048.
- مكتب Medi-Cal للحقوق المدنية على الرقم 916-440-7370 ويجب على مستخدمي TTY الاتصال على الرقم 711.
- 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

Մենք պետք է ապահովենք, որ **բոլոր** ծառայությունները, թե՛ կլինիկական, թե՛ ոչ կլինիկական, ձեզ մատուցվում են մշակութային առումով գրագետ և մատչելի եղանակով, այդ թվում՝ անգլերենի սահմանափակ իմացություն, սահմանափակ ընթերցանության հմտություններ, լսողության խանգարում ունեցող կամ բազմազան մշակութային և էթնիկ ծագում ունեցող անձանց համար: 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 ձեզ նյութեր տրամադրել նաև անգլերենից բացի այլ լեզուներով, այդ թվում՝ արաբերեն, հայերեն, կամբոջերեն (քմերերեն), Հեշտացված չինարեն, Ավանդական չինարեն, պարսկերեն, հինդի, հինդու, ճապոներեն, կորեերեն, լատներեն, միեն, փենջաբի, ռուսերեն, իսպաներեն, տագալերեն, թայերեն, ուկրաիներեն և վիետնամերեն, ինչպես նաև խոշոր տառատեսակով, Բրայլի գրերով կամ աուդիո ձևաչափերով: Այս այլընտրանքային ձևաչափերից որևէ մեկով նյութեր ստանալու համար խնդրում ենք զանգահարել Անդամների սպասարկման կենտրոն կամ գրել Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007 հասցեին:
- 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: Մա նշանակում է, որ մենք ամեն տարի նույն փաստաթղթերը կուղարկենք ձեր պահանջած ձևաչափով և լեզվով:
- Զանգահարեք Անդամների սպասարկման կենտրոն այս էջի ներքևում նշված հեռախոսահամարով՝ կանոնավոր պատվերը փոխելու կամ չեղարկելու համար: Դուք կարող եք նաև գտնել ձեր փաստաթղթերն առցանց՝ www.anthem.com/ca:



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/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:
- Medi-Cal Քաղաքացիական իրավունքների գրասենյակ՝ 916-440-7370: TTY-ից օգտվողները պետք է զանգահարեն՝ 711:
- ԱՄՆ Առողջապահության և մարդկային ծառայությունների վարչության Քաղաքացիական իրավունքների գրասենյակ՝ 1-800-368-1019: TTY-ից օգտվողները պետք է զանգահարեն՝ 1-800-537-7697:



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. 您有权以所需方式获得服务和信息

我们必须确保**所有**临床和非临床服务均以符合文化要求且易于理解的方式提供给您，包括英语能力有限、阅读能力有限、听力障碍或具有不同文化和种族背景的人。我们还必须以您能够了解的方式告知您本计划的福利以及您的权利。在您加入本计划期间，我们必须每年均将您的权利告知您。

- 如欲以您能够了解的方式取得信息，请致电会员服务部。我们的计划提供免费口译服务，可以用不同语言回答问题。
- 我们的计划还可以为您提供英语以外其他语言的数据，包括阿拉伯语、亚美尼亚语、柬埔寨语（高棉语）、简体中文、繁体中文、波斯语、印地语、苗语、日语、韩语、老挝语、缅甸语、旁遮普语、俄语、西班牙语、他加禄语、泰语、乌克兰语和越南语，以及大字体、盲文或音频等格式的数据。要取得这些替代格式之一的数据，请致电会员服务部或写信给 Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007。
- 您可以免费取得此档案的其他语言和格式版本，例如大号字体印刷版、盲文或音讯。致电会员服务部，电话号码见本页底部。致电时，请告知我们您是否希望这是一项常规订单。这意味着我们每年都会以您要求的格式和语言发送相同的文档。
- 致电本页底部列出的号码联系会员服务部，以更改或取消长期订单。您也可以从 www.anthem.com/ca 在线寻找您的文档。

如果您因语言问题或残障而无法从我们的计划中获得信息，并且您想提交投诉，请致电：

- Medicare，电话是 1-800-MEDICARE (1-800-633-4227)。您可每周7天，每天24小时拨打该电话。TTY 用户应致电 1-877-486-2048。
- Medi-Cal 民权办公室，电话是 916-440-7370。TTY 用户应致电 711。
- 美国卫生与大众服务部民权办公室，电话是 1-800-368-1019。TTY 用户应致电 1-800-537-7697。



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. 您有權以所需方式獲得服務和資訊

我們必須確保**所有**臨床和非臨床服務均以符合文化要求且易於理解的方式提供給您，包括英語能力有限、閱讀能力有限、聽力障礙或具有不同文化和種族背景的人。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。在您加入本計劃期間，我們必須每年均將您的權利告知您。

- 如欲以您能夠瞭解的方式取得資訊，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。
- 我們的計劃還可以為您提供英語以外其他語言的資料，包括阿拉伯語、亞美尼亞語、柬埔寨語（高棉語）、簡體中文、繁體中文、波斯語、印地語、苗語、日語、韓語、老撾語、緬甸語、旁遮普語、俄語、西班牙語、他加祿語、泰語、烏克蘭語和越南語，以及大字體、盲文或音頻等格式的資料。要取得這些替代格式之一的資料，請致電會員服務部或寫信給 Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007。
- 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。
- 致電本頁底部列出的號碼聯絡會員服務部，以變更或取消長期訂單。您也可以從 www.anthem.com/ca 在線上尋找您的文件。

如果您因語言問題或殘障而無法從我們的計劃中獲得資訊，並且您想提交投訴，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。TTY 用戶應致電 1-877-486-2048。
- Medi-Cal 民權辦公室，電話是 916-440-7370。TTY 用戶應致電 711。
- 美國衛生與大眾服務部民權辦公室，電話是 1-800-368-1019。TTY 用戶應致電 1-800-537-7697。



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

ما باید اطمینان حاصل کنیم که همه خدمات، اعم از بالینی و غیربالینی، به شیوه‌ای متناسب با فرهنگتان و دسترس‌پذیر به شما ارائه می‌شود، از جمله برای افراد دارای مهارت محدود انگلیسی، مهارت‌های محدود خواندن، ناتوانی شنوایی، یا افراد دارای پیشینه فرهنگی و قومیتی متفاوت. 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 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 مطالب را به زبان‌های غیر از انگلیسی از جمله عربی، ارمنی، کامبوجی (خمر)، چینی ساده‌شده، چینی سنتی فارسی، هندی، همونگ، ژاپنی، کره‌ای، لائوسی، مین، پنجابی، روسی، اسپانیایی، تاگالوگ، تایلندی، اوکراینی و ویتنامی و در فرمت‌هایی مانند چاپ درشت، خط بریل یا فایل صوتی در اختیار شما قرار دهد. برای دریافت مطالب در یکی از این فرمت‌های جایگزین، لطفاً با خدمات اعضا تماس بگیرید یا به این آدرس نامه بفرستید: Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
 - می‌توانید این سند را به‌صورت رایگان در زبان‌ها و فرمت‌های دیگر مانند چاپ درشت، خط بریل یا فرمت صوتی دریافت کنید. با خدمات اعضا به شماره مندرج در پایین این صفحه تماس بگیرید. اگر می‌خواهید این درخواست را به عنوان 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.
 - برای تغییر یا لغو درخواست دائمی، با خدمات اعضا به شماره مندرج در پایین این صفحه تماس بگیرید. می‌توانید مدارک خود را آنلاین در www.anthem.com/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 1-800-MEDICARE (1-800-633-4227). می‌توانید در 24 ساعت شبانه‌روز و 7 روز هفته تماس بگیرید. کاربران TTY باید با 1-877-486-2048 تماس بگیرند.
 - دفتر حقوق مدنی Medi-Cal به شماره 916-440-7370. کاربران TTY باید با 711 تماس بگیرند.
 - دفتر حقوق مدنی در وزارت بهداشت و خدمات انسانی آمریکا به شماره تلفن 1-800-368-1019. کاربران TTY باید با 1-800-537-7697 تماس بگیرند.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. आपकी सेवाएँ और जानकारी पाने का अधिकार, जो आपकी ज़रूरतों के अनुसार हों

हमें यह सुनिश्चित करना होगा कि **सभी** सेवाएँ, चाहे वे क्लिनिकल हों या गैर-क्लिनिकल, आपको सांस्कृतिक रूप से सक्षम और सुलभ तरीके से प्रदान की जाएँ, इसमें सीमित अंग्रेज़ी दक्षता, सीमित पठन कौशल, सुनने में अक्षमता, या विविध सांस्कृतिक और जातीय पृष्ठभूमि वाले लोग शामिल हैं। हमें आपको अपनी योजना के लाभों और आपके अधिकारों के बारे में भी इस तरह से बताना होगा कि आप इसे समझ सकें। जब तक आप हमारी योजना में हैं, हमें हर साल आपको आपके अधिकारों के बारे में बताना होगा।

- जानकारी को अपनी समझ के अनुसार पाने के लिए, मेंबर सेवाओं सेवा को कॉल करें। हमारी योजना में विभिन्न भाषाओं में सवालों के जवाब देने के लिए मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं।
- हमारी योजना आपको अंग्रेज़ी के अलावा अन्य भाषाओं में भी सामग्री दे सकती है, जैसे अरबी, अर्मेनियाई, कंबोडियन (खमेर), चीनी सरलीकृत, चीनी पारंपरिक, फ़ारसी, हिंदी, हमोंग, जापानी, कोरियाई, लाओटियन, मिएन, पंजाबी, रूसी, स्पेनिश, तागालोग, थाई, यूक्रेनी, और वियतनामी। यह सामग्री बड़े प्रिंट, ब्रेल, या ऑडियो जैसे प्रारूपों में भी उपलब्ध है। इन वैकल्पिक प्रारूपों में सामग्री पाने के लिए, कृपया मेंबर सेवाओं को कॉल करें या Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007 पर लिखें।
- आप इस दस्तावेज़ को मुफ्त में अन्य भाषाओं और प्रारूपों में पा सकते हैं, जैसे बड़े प्रिंट, ब्रेल या ऑडियो। इस पृष्ठ के नीचे दिए गए नंबर पर मेंबर सेवाओं को कॉल करें। जब आप कॉल करें, तो हमें बताएं कि क्या आप इसे एक स्थायी आदेश बनाना चाहते हैं। इसका मतलब है कि हम हर साल आपके अनुरोधित प्रारूप और भाषा में वही दस्तावेज़ भेजेंगे।
- स्थायी आदेश को बदलने या रद्द करने के लिए, इस पृष्ठ के नीचे सूचीबद्ध नंबर पर मेंबर सेवाओं को कॉल करें। आप अपने दस्तावेज़ www.anthem.com/ca पर ऑनलाइन भी देख सकते हैं।

यदि आपको भाषा संबंधी समस्याओं या किसी विकलांगता के कारण हमारी योजना से जानकारी प्राप्त करने में परेशानी होती है और आप शिकायत दर्ज करना चाहते हैं, तो इन पर कॉल करें:

- Medicare को 1-800-MEDICARE (1-800-633-4227) पर कॉल करें। आप सप्ताह के सातों दिन, 24 घंटे कॉल कर सकते हैं। TTY उपयोगकर्ता 1-877-486-2048 पर कॉल करें।
- Medi-Cal नागरिक अधिकार कार्यालय को 916-440-7370 पर कॉल करें। TTY उपयोगकर्ता 711 पर कॉल करें।
- अमेरिकी स्वास्थ्य एवं मानव सेवा विभाग, नागरिक अधिकार कार्यालय को 1-800-368-1019 पर कॉल करें। TTY उपयोगकर्ता 1-800-537-7697 पर कॉल करें।



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. Koj li kev muaj cai tau txais cov kev pab cuam thiab tej ntaub ntawv nyob rau txoj hauv kev uas koj xav tau.

Peb yuav tsum xyuas kom meej **tag nrho** cov kev pab cuam, ob qho tib si qhov kho mob thiab tsis yog kho mob, muab kom raws li tej kab lig kev cai uas koj paub thiab siv tau suav nrog rau cov uas tsis txawj lus Askiv, nyeem tsis tau zoo, tsis hnov zoo los sis ntau yam kab lig kev cai thiab keeb kwm kev coj. Peb kuj tseem yuav tsum tau qhia koj txog peb txoj phiaj xwm cov kev pab cuam thiab koj li kev muaj cai raws li qhov koj to taub. Peb yuav tsum qhia koj txog koj li kev muaj cai txhua xyoo uas koj nyob hauv peb lub phiaj xwm.

- Txhawm rau kom tau txais nyob rau txoj hauv kev uas koj nkag siab, hu Lub Chaw Pab Cuam Tswv Cuab. Peb txoj phiaj xwm muaj kev txhais lus pub dawb txhawm rau teb cov lus nug ua ntau hom lus.
- Peb lub phiaj xwm los kuaj muab cov ntaub ntawv txhais ua lwm yam lus dhau ntawm lus Askiv suav nrog lus Aslas Npiv, Asmes Nias, Kaspus Cias (Khab Mawm), Lus Suav Ib Txwm Siv, Lus Suav Qub Thaum Ub, Fasxis, Hidus, Hmoob, Zij Pee, Kauslim, Nplog, Co, Pascas Npis, Lav Xias, Xab Pees, Tas Kas Los, Thaib, Yus Khees, thiab Nyab Laj, thiab ua lwm cov qauv ntawv xws li luam loj, ntawv xuas, los sis kaw suab. Txhawm rau kom tau txais cov ntaub ntawv ua lwm tus qauv ntawv, thov hu Lub Chaw Pab Cuam Tswv Cuab los sis sau ntawv rau Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- Koj tuaj yeem tau txais cov ntaub ntawv no dawb ua lwm hom lus thiab lwm yam qauv ntawv, xws li luam ua tus ntawv loj, ntawv su thiab ua suab. Hu Lub Chaw Pab Cuam Tswv Cuab ntawm tus nab npawb xov tooj uas tau teev tseg nyob rau hauv qab ntawm nplooj no. Thaum hu mus, qhia rau peb paub yog tias koj xav kom ua qhov no raws li lus txib. Qhov ntawd txhais tau tias peb yuav xa tib cov ntaub ntawv ua tus qauv thiab hom lus uas koj tau thov txhua xyoo.
- Hu Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj muab teev tseg nyob rau hauv qab ntawm nplooj no los thov hloov los sis thim qhov uas thov mus kom ua li qub. Dhau li ntawd lawm koj kuj tuaj yeem nrhiav tau koj cov ntaub ntawv hauv oos lais ntawm www.anthem.com/ca.

Yog koj muaj teeb meem txog kev tau txais cov txheej xwm los ntawm peb txoj phiaj xwm vim muaj teeb meem txog lus los sis xiam oob qhab thiab koj xav hais kev tsis txaus siab, hu rau:

- Medicare ntawm 1-800-MEDICARE (1-800-633-4227). Koj tuaj yeem hu tau 24 teev ib hnuv, 7 hnuv ib vij. Cov neeg siv TTY hu rau 1-877-486-2048.
- Medi-Cal Lub Chaw Ua Hauj Lwm Saib Xyuas Pej Xeem Kev Muaj Cai ntawm 916-440-7370. Cov neeg siv TTY hu rau 711.
- Lub Tuam Tsev Hauj Lwm Saib Xyuas Kev Noj Qab Haus Huv thiab Pab Cuam Tib Neeg Teb Chaws Meskas, Lub Chaw Ua Hauj Lwm Saib Xyuas Pej Xeem Kev Muaj Cai ntawm 1-800-368-1019. Cov neeg siv TTY hu rau 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. ニーズに合った方法でサービスや情報を得る権利

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- 理解しやすい形で情報を得るには、会員サービスまでお問い合わせください。当社のプランでは、さまざまな言語で質問にお答えする無料の通訳サービスをご利用いただけます。
- また、英語以外の言語（アラビア語、アルメニア語、カンボジア語（クメール語）、簡体中国語、繁体中国語、ペルシャ語、ヒンディー語、モン族語、日本語、韓国語、ラオス語、ミエン語、パンジャブ語、ロシア語、スペイン語、タガログ語、タイ語、ウクライナ語、ベトナム語）での資料もご用意しており、拡大印刷、点字、音声などの形式でも提供しています。これらの代替形式で資料を入手するには、会員サービスにお電話いただくか、Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007まで書面でご連絡ください。
- この文書は、拡大印刷、点字、音声などの他の言語や形式でも無料でご利用いただけます。このページ下部に記載されている電話番号まで、会員サービスにお問い合わせください。お電話の際には、定期配送をご希望かどうかをお知らせください。定期配送をご希望の場合、ご要望の形式と言語で同じ文書を毎年お届けいたします。
- 定期配送の変更またはキャンセルをご希望の場合は、このページ下部に記載されている電話番号まで会員サービスにお問い合わせください。また、書類は www.anthem.com/ca からオンラインでご覧いただけます。

言語の問題や障害のために当社のプランに関する情報の入手が困難で、苦情を申し立てたい場合は、以下までお電話ください。

- Medicare, 1-800-MEDICARE (1-800-633-4227)にご連絡ください。24時間365日いつでもご利用いただけます。TTYをご利用の方は、1-877-486-2048にお電話ください。
- Medi-cal 公民権局へは、916-440-7370にご連絡ください。TTYをご利用の方は、711にお電話ください。
- 米国保健福祉省公民権局へは、1-800-368-1019にご連絡ください。TTYをご利用の方は、1-800-537-7697にお電話ください。



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. អ្នក ន សិទ្ធិ ទទួល បានសេវាកម្ម និង ព័ត៌មាន តាម មធ្យោបាយ ណា មួយ ដែល អ្នក ពេញចិត្ត

យើងត្រូវតែធានាថាសេវាកម្មទាំងអស់ ទាំងសេវាកម្មគ្លីនិក និងមិនមែនគ្លីនិក ត្រូវបានផ្តល់ជូនអ្នកតាមលក្ខណៈ រហ័ស និងអាចចូលប្រើបាន រួមទាំងសម្រាប់អ្នកដែលមានជំនាញភាសាអង់គ្លេសមានកម្រិត ជំនាញអានមាន កម្រិត អសមត្ថភាពខាងការស្តាប់ ឬអ្នកដែលមានប្រវត្តិរហ័ស និងជាតិសាសន៍ចម្រុះ។ យើងក៏ត្រូវប្រាប់អ្នក អំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកតាមវិធីដែលអ្នកអាចយល់បាន។ យើងត្រូវប្រាប់អ្នក អំពីសិទ្ធិរបស់អ្នករៀងរាល់ឆ្នាំដែលអ្នកស្ថិតនៅក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មានក្នុងទម្រង់ដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅផ្នែកសេវាបម្រើសមាជិក។ គម្រោងរបស់យើងមានសេវាកម្មបកប្រែផ្ទាល់មាត់ឥតគិតថ្លៃដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។
- គម្រោងរបស់យើងក៏អាចផ្តល់ឱ្យអ្នកនូវឯកសារជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស រួមមាន ភាសាអារ៉ាប់ អាមេនី កម្ពុជា (ខ្មែរ) ចិនសាមញ្ញ ចិនបុរាណ ហ្វាស៊ី ហិណ្ឌូ ម៉ុង ជប៉ុន កូរ៉េ ឡាវ ម៉ឺន ពុនចាប៊ី រុស្ស៊ី អេស្ប៉ាញ តាកាវ៉ា ថៃ អ៊ុយក្រែន និងវៀតណាម និងក្នុងទម្រង់ដូចជាអក្សរពុម្ពធំ អក្សរស្លាប ឬសំឡេង។ ដើម្បីទទួលបានឯកសារជាទម្រង់ជំនួសណាមួយទាំងនេះ សូមទូរសព្ទទៅផ្នែកសេវាបម្រើសមាជិក ឬសរសេរទៅ Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007។
- អ្នកអាចទទួលបានឯកសារនេះដោយឥតគិតថ្លៃតាមទម្រង់ និងភាសាផ្សេងៗដូចជា ការបោះ ពុម្ពអក្សរធំៗ អក្សរសម្រាប់មនុស្សពិការភ្នែក ឬជាសំឡេង។ ទូរសព្ទទៅកាន់ផ្នែកសេវាបម្រើសមាជិកតាម លេខទូរសព្ទ ដែលរាយនៅផ្នែកខាងក្រោមនៃទំព័រនេះ។ នៅពេលហៅទូរសព្ទ សូមប្រាប់យើងប្រសិនបើអ្នក កង់ដាក់វាជាសំណើជាអចិន្ត្រៃយ៍។ មានន័យថា យើងនឹងផ្ញើឯកសារដូចគ្នាទៅតាមទម្រង់ និងភាសាដែលអ្នកបានស្នើសុំជារៀងរាល់ឆ្នាំ។
- ទូរសព្ទទៅកាន់ផ្នែកសេវាបម្រើសមាជិកតាមលេខទូរសព្ទ ដែលរាយនៅផ្នែកខាងក្រោមនៃទំព័រនេះ ដើម្បីផ្លាស់ប្តូរ ឬលុបចោលការបង្កាប់បញ្ជាជាអចិន្ត្រៃយ៍ណាមួយ។ អ្នកក៏អាចស្វែងរកឯកសាររបស់ អ្នកលើអ៊ីនធឺណិតបានផងដែរតាមរយៈគេហទំព័រ www.anthem.com/ca។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹង សូមហៅទូរសព្ទទៅ៖

- Medicare តាមរយៈលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចហៅបាន 24 ម៉ោងក្នុង មួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកប្រើប្រាស់ TTY គួរទូរសព្ទទៅលេខ 1-877-486-2048។
- ការិយាល័យសិទ្ធិស៊ីវិលរបស់ Medi-Cal តាមរយៈលេខ 916-440-7370។ អ្នកប្រើប្រាស់ TTY គួរហៅទូរសព្ទទៅ លេខ 711។
- ក្រសួងសុខាភិបាល និងសេវាមនុស្សជាតិ ការិយាល័យសិទ្ធិស៊ីវិលតាមលេខ 1-800-368-1019។ អ្នកប្រើ ប្រាស់ TTY គួរទូរសព្ទទៅលេខ 1-800-537-7697។



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

A. 요구 사항을 충족할 수 있는 방식으로 서비스와 정보를 얻을 가입자의 권리

당사는 모든 임상 및 비임상 서비스가 영어 구사력이 부족한 사람, 읽기 능력이 부족한 사람, 청각 장애가 있는 사람, 문화나 민족적 배경이 다양한 사람을 포함하여 문화적으로 적합하고 접근 가능한 방식으로 제공될 수 있도록 해야 합니다. 가입자가 이해할 수 있는 방법으로 플랜의 혜택 및 가입자 권리를 설명해야 합니다. 또한 가입자가 저희 플랜에 가입한 후 매년 가입자의 권리에 대해 알려야 합니다.

- 귀하께서 이해 가능한 방식으로 정보를 얻으려면 가입자 서비스부로 전화해 주십시오. 저희 플랜에는 다양한 언어로 질문에 답변해줄 통역사 서비스가 있습니다.
- 또한 아랍어, 아르메니아어, 캄보디아어(크메르어), 중국어 간체, 중국어 번체, 페르시아어, 힌두어, 몽어, 일본어, 한국어, 라오스어, 미엔어, 편자브어, 러시아어, 스페인어, 타갈로그어, 태국어, 우크라이나어 및 베트남어 등 영어 이외의 언어와 대형 활자체, 점자, 오디오와 같은 형식의 자료를 제공해드릴 수도 있습니다. 이러한 대체 형식 중 하나로 자료를 얻으시려면 가입자 서비스부에 전화하시거나 Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007로 서신을 보내주시기 바랍니다.
- 본 문서는 대형 활자체, 점자 또는 오디오와 같은 기타 언어 및 형식으로 무료로 제공해 드릴 수 있습니다. 이 페이지 하단에 안내된 번호로 가입자 서비스부에 전화해 주십시오. 전화를 거실 때, 형식 또는 언어에 대한 귀하의 요청이 앞으로도 상시 지시로 적용되기를 원하는지 알려주십시오. 그렇게 원하시면 요청하신 형식과 언어로 매년 동일한 서류를 보내드릴 것입니다.
- 이 페이지 하단에 기재된 번호로 가입자 서비스부에 전화하여 대기 중인 주문을 변경하거나 취소하십시오. 귀하의 문서는 온라인(www.anthem.com/ca)으로도 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). 주 7일 하루 24시간 언제든지 문의하실 수 있습니다. TTY 사용자는 1-877-486-2048번을 이용해 주십시오.
- Medi-Cal 민권 담당국: 916-440-7370. TTY 사용자는 711번으로 전화해야 합니다.
- 미국 보건복지부, 시민권청, 1-800-368-1019. TTY 사용자는 1-800-537-7697번을 이용해 주십시오.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. ສິດທິຂອງທ່ານທີ່ໄດ້ຮັບການບໍລິການ ແລະ ຂໍ້ມູນໃນວິທີການທີ່ຕອບສະໜອງຕາມຄວາມຕ້ອງການຂອງທ່ານ

ພວກເຮົາຕ້ອງເຮັດໃຫ້ແນ່ໃຈວ່າການບໍລິການ ທັງໝົດ, ທັງທາງດ້ານຄລີນິກ ແລະ ທີ່ບໍ່ແມ່ນທາງດ້ານຄລີນິກ, ແມ່ນສະໜອງໃຫ້ແກ່ທ່ານໃນລັກສະນະທີ່ເໝາະສົມທາງດ້ານວັດທະນະທຳ ແລະ ເຂົ້າເຖິງໄດ້ ລວມທັງສຳລັບຜູ້ທີ່ມີຄວາມຮູ້ຄວາມສາມາດດ້ານພາສາອັງກິດທີ່ຈຳກັດ, ທັກສະການອ່ານທີ່ຈຳກັດ, ຄວາມພິການໃນການໄດ້ຍິນ, ຫຼືຜູ້ທີ່ມີພື້ນຖານວັດທະນະທຳ ແລະ ຊົນເຜົ່າທີ່ຫຼາກຫຼາຍ. ພວກເຮົາຍັງຕ້ອງບອກທ່ານກ່ຽວກັບຜົນປະໂຫຍດຂອງແຜນຂອງພວກເຮົາ ແລະ ສິດທິຂອງທ່ານໃນວິທີທີ່ທ່ານສາມາດເຂົ້າໃຈໄດ້. ພວກເຮົາຕ້ອງບອກທ່ານກ່ຽວກັບສິດທິຂອງທ່ານໃນແຕ່ລະປີທີ່ທ່ານຢູ່ໃນແຜນການຂອງພວກເຮົາ.

- ເພື່ອໃຫ້ໄດ້ຮັບຂໍ້ມູນໃນວິທີທີ່ທ່ານສາມາດເຂົ້າໃຈໄດ້, ໂທຫາຝ່າຍບໍລິການສະມາຊິກ. ແຜນການຂອງພວກເຮົາມີບໍລິການນາຍພາສາພຣີເພື່ອຕອບຄຳຖາມເປັນພາສາຕ່າງໆ.
- ແຜນການຂອງພວກເຮົາຍັງສາມາດໃຫ້ທ່ານເປັນພາສາອື່ນນອກເໜືອໄປຈາກພາສາອັງກິດລວມທັງ ອາຣັບ, ອາເມເນຍ, ກຳປູເຈຍ (ຂະເໝນ), ພາສາຈີນທົ່ວໄປ, ພາສາຈີນພື້ນເມືອງ, ພາຊີ, ຮິນດູ, ມົງ, ອິນດູ, ເກົາຫຼີ, ລາວ, ມຽນ, ບັນຈາບີ, ລັດເຊຍ, ສະເປນ, ຕາກາລັອກ, ໄທ, ອູແກຣນ ແລະ ຫວຽດນາມ ແລະ ໃນຮູບແບບຕ່າງໆເຊັ່ນ ຕົວພິມໃຫຍ່, ອັກສອນນູນ, ຫຼື ສຽງ. ເພື່ອໃຫ້ໄດ້ຮັບເອກະສານໃນຮູບແບບທາງເລືອກເຫຼົ່ານີ້, ກະລຸນາໂທຫາຝ່າຍບໍລິການສະມາຊິກ ຫຼື ຂຽນຈົດໝາຍຫາ Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- ທ່ານສາມາດໄດ້ຮັບເອກະສານນີ້ສຳລັບການຟຣີໃນພາສາ ແລະ ຮູບແບບອື່ນໆ, ເຊັ່ນ ການພິມຂະໜາດໃຫຍ່, ຕົວອັກສອນ ຫຼື ສຽງ. ໂທ ຝ່າຍບໍລິການສະມາຊິກ ທີ່ໝາຍລະບຸໄວ້ຢູ່ລຸ່ມສຸດຂອງໜ້ານີ້. ເວລາໂທຫາ, ແຈ້ງໃຫ້ພວກເຮົາຮູ້ວ່າທ່ານຕ້ອງການໃຫ້ມັນເປັນຄຳຄົງທີ່. ນັ້ນໝາຍຄວາມວ່າພວກເຮົາຈະສົ່ງເອກະສານດຽວກັນໃນຮູບແບບ ແລະ ພາສາທີ່ທ່ານຮ້ອງຂໍທຸກໆປີ.
- ໂທ ຝ່າຍບໍລິການສະມາຊິກຕາມໝາຍເລກທີ່ລະບຸໄວ້ຢູ່ລຸ່ມສຸດຂອງໜ້ານີ້ເພື່ອປ່ຽນແປງ ຫຼື ຍົກເລີກຄຳສັ່ງຄົງທີ່. ນອກນັ້ນທ່ານຍັງສາມາດຊອກຫາເອກະສານຂອງທ່ານອອນໄລນ໌ຢູ່ www.anthem.com/ca.

ຖ້າທ່ານມີບັນຫາໃນການໄດ້ຮັບຂໍ້ມູນຈາກແຜນຂອງພວກເຮົາເນື່ອງຈາກບັນຫາດ້ານພາສາ ຫຼື ຄວາມພິການ ແລະ ທ່ານຕ້ອງການຍື່ນຄຳຮ້ອງທຸກ, ໃຫ້ໂທຫາ:

- Medicare ຢູ່ 1-800-MEDICARE (1-800-633-4227). ທ່ານສາມາດໂທໄດ້ 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ. ຜູ້ໃຊ້ TTY ຄວນໂທຫາ 1-877-486-2048.
- Medi-Cal ຫ້ອງການສິດທິຜົນລະເມືອງ ທີ່ 916-440-7370. ຜູ້ໃຊ້ TTY ຄວນໂທຫາ 711.
- ພະແນກ ສາທາລະນະສຸກ ແລະ ການບໍລິການມະນຸດ ຂອງສະຫະລັດ, ຫ້ອງການສິດທິຜົນລະເມືອງຢູ່ 1-800-368-1019. ຜູ້ໃຊ້ TTY ຄວນໂທຫາ 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

A. Maaih leiz beu ze'buonc bun meih liouh zipv ziux qiemx nyei jauv-louc aengx caux douc waac-fienx mbuox bun hiuv taux ziux meih nyungc nyei jauv-louc

Yie mbuo a'zuqc mbungh goux **yietc zungv** gong, yiem zorc baengc dornx aengx caux mv zeiz yiem zorc baengc dornx goux nzoih yi nyungc, liouh tengx meih zoux ziangx nzoih yietc zungv gong aengx caux mv haih gorngv janx-yaangh yinh waac nyei mienh haih bieqc lorz duqv zaac naaiv deix gong, lemh nzoih mv haih doqc nzangc mbiaangc nyei mienh, m'normh ndung waaic, a'fai ninh mbuo lox-hnoi gueix-jei aengx caux benx haaix nyungc fiuv fingx mienh yaac bun nzoih. Yie mbuo a'zuqc mbuox meih hiuv taux yie mbuo nyei heng-wangc sou-gorn nyaanh aengx caux maaih leiz beu ze'buonc bun liouh douc mbuox meih bieqc hnyiouuv nzoih yietc zungv. Yie mbuo a'zuqc mbuox meih hiuv taux maaih haaix nyungc leiz beu ze'buonc bun meih yiem njiec hnyiang-dong dugh corc bieqc yiem yie mbuo nyei heng-wangc sou-gorn nyei ziangh hoc.

- Se gorngv oix zipv muangx waac-fienx tipv faaux ziux haaix nyungc dugh haih tengx meih bieqc hnyiouuv longx wuov, mborqv finx lorz maaih leiz beu ze'buonc bun mienh nyei dornx. Yie mbuo nyei heng-wangc sou-gorn wuov bung mbenc maaih porv waac mienh liouh wangv henh dau benx meih wuov fingx mienh nyei waac bun muangx mv zuqc ndortv nyaanh.
- Yiem njiec yie mbuo nyei heng-wangc sou-gorn corc maaih naaiv deix jaa-dornx fiev benx camv-fingx waac liouh bun meih mangc, lemh nzoih fiev benx Arabic, Armenian, Janx-Cambodian (Khmer), Janx-kaeqv siang-nzangc, Janx-kaeqv lox-hnoi nzangc, Farsi, Hindi, Janx-bu'miuh, Janx-yih benv, Janx-Korean, Janx-laauv waac, Mienh waac, Punjabi, Russian, Spanish, Tagalog, Janx-taiv waac, Ukrainian aengx caux Vietnamese caux zoux cuotv ziex nyungc daan bun longc dugh aamx bieqc domh zeiv, nzangc-pokc bun hlou, a'fai benx waac-qiez bun muangx. Se gorngv qiemx zuqc zipv longc naaiv deix jaa-dornx benx haaix horngh naaiv deix jaa-sic wuov, daaix luic mborqv finx lorz maaih leiz beu ze'buonc bun mienh nyei dornx a'fai fiev sou fungx bun taux Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- Meih corc haih duqv zipv longc naaiv deix nyungc horngh sou benx ziex fingx waac mv zuqc ndortv nyaanh aengx caux zoux benx nyungc horngh daan, dugh aamx bieqc domh zeiv, nzangc-pokc bun hlou, a'fai benx waac-qiez bun muangx. Mborqv finx lorz maaih leiz beu ze'buonc bun mienh nyei dornx ziux naaiv norm nam mber fiev yiem ga'ndiev juoqv yiemc sou wuov. Haaix zanc mborqv finx lorz nyei ziangh hoc, oix zuqc mbuox tong yie mbuo hiuv gorngv meih oix heuc paaiv benx dingc-torqv haapc maaz waac. Ninh zeiz gorngv yie mbuo a'zuqc fungx dongh nyungc sou ziux meih tov taux nyei buonc aengx caux benx naaic fingx waac ziux hnyiang-dong mingh bun.
- Mborqv finx lorz maaih leiz beu ze'buonc bun mienh nyei dornx ziux naaiv norm nam mber fiev yiem ga'ndiev juoqv yiemc sou wuov liouh tiuv yienc siang a'fai tuix guangc dingc-torqv haapc maaz waac. Meih corc haih bieqc zaah lorz mangc taux naaiv deix nyungc horngh sou yangh online yiem lorqc njiec naaiv www.anthem.com/ca.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Beiv hnangv maaih dorngh zorv nyaav zuqc meih mv haih zipv muangx waac-fienx yiem caux yie mbuo nyei heng-wangc sou-gorn weic laaix benx zuqc mv haih gorngv naaic fingx waac a'fai benx waaic fangx mienh aengx caux haix oix zoux sou fungx bieqc guaix taux, mborqv finx lorz taux:

- Medicare yiem lorqc njiec naaiv 1-800-MEDICARE (1-800-633-4227). Yietc hnoi mborqv finx lorz duqv 24 norm ziangh hoc, yietc norm leiz baaix lorz duqv 7 hnoi. Haaix deix mienh longc TTY nyei buonc horpc zuc mborqv finx lorz taux 1-877-486-2048.
- Medi-Cal nyei weic goux taux leiz beu ze'buonc bun baeqc fingx yiem lorqc njiec naaiv 916-440-7370. Haaix deix mienh longc TTY nyei buonc horpc zuqc mborqv finx lorz taux 711.
- Meiv guoqv domh gorn goux taux baeqc fingx mienh maanh heng-wangc aengx caux baengc zingh gong-bou jauv-louc, naaiv norm weic goux leiz beu ze'buonc bun baeqc fingx yiem lorqc njiec naaiv 1-800-368-1019. Haaix deix mienh longc TTY nyei buonc horpc zuc mborqv finx lorz taux 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. ਤੁਹਾਡੀਆਂ ਜ਼ਰੂਰਤਾਂ ਨੂੰ ਪੂਰਾ ਕਰਨ ਵਾਲੇ ਤਰੀਕੇ ਨਾਲ ਸੇਵਾਵਾਂ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਤੁਹਾਡਾ ਅਧਿਕਾਰ

ਸਾਨੂੰ ਇਹ ਯਕੀਨੀ ਬਣਾਉਣਾ ਚਾਹੀਦਾ ਹੈ ਕਿ **ਸਾਰੀਆਂ** ਸੇਵਾਵਾਂ, ਕਲੀਨਿਕਲ ਅਤੇ ਗੈਰ-ਕਲੀਨਿਕਲ ਦੇਵੇਂ, ਤੁਹਾਨੂੰ ਸੱਭਿਆਚਾਰਕ ਤੌਰ 'ਤੇ ਸਮਰੱਥ ਅਤੇ ਪਹੁੰਚਯੋਗ ਢੰਗ ਨਾਲ ਪ੍ਰਦਾਨ ਕੀਤੀਆਂ ਜਾਂਦੀਆਂ ਹਨ, ਜਿਸ ਵਿੱਚ ਸੀਮਤ ਅੰਗਰੇਜ਼ੀ ਮੁਹਾਰਤ, ਸੀਮਤ ਪੜ੍ਹਨ ਦੇ ਹੁਨਰ, ਸੁਣਨ ਦੀ ਅਯੋਗਤਾ, ਜਾਂ ਵਿਭਿੰਨ ਸੱਭਿਆਚਾਰਕ ਅਤੇ ਨਸਲੀ ਪਿਛੋਕੜ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਸ਼ਾਮਲ ਹਨ। ਸਾਨੂੰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਯੋਜਨਾ ਦੇ ਲਾਭਾਂ ਅਤੇ ਤੁਹਾਡੇ ਅਧਿਕਾਰਾਂ ਬਾਰੇ ਇਸ ਤਰੀਕੇ ਨਾਲ ਵੀ ਦੱਸਣਾ ਚਾਹੀਦਾ ਹੈ ਕਿ ਤੁਸੀਂ ਸਮਝ ਸਕੋ। ਸਾਨੂੰ ਹਰ ਸਾਲ ਤੁਹਾਡੇ ਅਧਿਕਾਰਾਂ ਬਾਰੇ ਦੱਸਣਾ ਚਾਹੀਦਾ ਹੈ ਕਿ ਤੁਸੀਂ ਸਾਡੀ ਯੋਜਨਾ ਵਿੱਚ ਹੋ।

- ਸਮਝ ਆਉਣ ਵਾਲੇ ਤਰੀਕੇ ਨਾਲ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਮੈਂਬਰ ਸੇਵਾ ਨੂੰ ਕਾਲ ਕਰੋ। ਸਾਡੀ ਯੋਜਨਾ ਵਿੱਚ ਵੱਖ-ਵੱਖ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਦੇਣ ਲਈ ਮੁਫਤ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ।
- ਸਾਡੀ ਯੋਜਨਾ ਤੁਹਾਨੂੰ ਅੰਗਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਜਿਸ ਵਿੱਚ ਅਰਬੀ, ਅਰਮੀਨੀਆਈ, ਕੰਬੋਡੀਅਨ (ਖਮੇਰ), ਚੀਨੀ ਸਰਲੀਕ੍ਰਿਤ, ਚੀਨੀ ਪਰੰਪਰਾਗਤ, ਫਾਰਸੀ, ਹਿੰਦੀ, ਹਮੋਗ, ਜਾਪਾਨੀ, ਕੋਰੀਅਨ, ਲਾਓਸ਼ੀਅਨ, ਮੀਆਂ, ਪੰਜਾਬੀ, ਰੂਸੀ, ਸਪੈਨਿਸ਼, ਤਾਗਾਲੋਗ, ਥਾਈ, ਯੂਕਰੇਨੀ ਅਤੇ ਵੀਅਤਨਾਮੀ ਸ਼ਾਮਲ ਹਨ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ, ਬ੍ਰੇਲ, ਜਾਂ ਆਡੀਓ ਵਰਗੇ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਵੀ ਸਮੱਗਰੀ ਦੇ ਸਕਦੀ ਹੈ। ਇਹਨਾਂ ਵਿੱਚੋਂ ਕਿਸੇ ਇੱਕ ਵਿਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਸਮੱਗਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਮੈਂਬਰ ਸੇਵਾ ਨੂੰ ਕਾਲ ਕਰੋ ਜਾਂ Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007 ਨੂੰ ਲਿਖੋ।
- ਤੁਸੀਂ ਇਹ ਦਸਤਾਵੇਜ਼ ਹੋਰ ਭਾਸ਼ਾਵਾਂ ਵਿੱਚ ਅਤੇ ਫਾਰਮੈਟਾਂ, ਜਿਵੇਂ ਕਿ ਵੱਡਾ ਪ੍ਰਿੰਟ, ਬ੍ਰੇਲ ਜਾਂ ਆਡੀਓ ਵਿੱਚ ਮੁਫਤ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਇਸ ਪੰਨੇ ਦੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਮੈਂਬਰ ਸੇਵਾ ਨੂੰ ਕਾਲ ਕਰੋ। ਕਾਲ ਕਰਦੇ ਸਮੇਂ, ਸਾਨੂੰ ਦੱਸੋ ਕਿ ਕੀ ਤੁਸੀਂ ਇਸਨੂੰ ਇੱਕ ਸਥਾਈ ਹੁਕਮ ਬਣਾਉਣਾ ਚਾਹੁੰਦੇ ਹੋ। ਇਸਦਾ ਮਤਲਬ ਹੈ ਕਿ ਅਸੀਂ ਹਰ ਸਾਲ ਤੁਹਾਡੇ ਬੇਨਤੀ ਕੀਤੇ ਫਾਰਮੈਟ ਅਤੇ ਭਾਸ਼ਾ ਵਿੱਚ ਉਹੀ ਦਸਤਾਵੇਜ਼ ਭੇਜਾਂਗੇ।
- ਸਥਾਈ ਆਰਡਰ ਨੂੰ ਬਦਲਣ ਜਾਂ ਰੱਦ ਕਰਨ ਲਈ ਇਸ ਪੰਨੇ ਦੇ ਹੇਠਾਂ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਮੈਂਬਰ ਸੇਵਾ ਨੂੰ ਕਾਲ ਕਰੋ। ਤੁਸੀਂ ਆਪਣੇ ਦਸਤਾਵੇਜ਼ ਐਨਲਾਈਨ ਵੀ www.anthem.com/ca 'ਤੇ ਲੱਭ ਸਕਦੇ ਹੋ।



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਭਾਸ਼ਾ ਸੰਬੰਧੀ ਸਮੱਸਿਆਵਾਂ ਜਾਂ ਅਪਾਹਜਤਾ ਕਾਰਨ ਸਾਡੀ ਯੋਜਨਾ ਤੋਂ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਵਿੱਚ ਮੁਸ਼ਕਲ ਆ ਰਹੀ ਹੈ ਅਤੇ ਤੁਸੀਂ ਫਰਿਆਦ ਦਰਜ ਕਰਵਾਉਣਾ ਚਾਹੁੰਦੇ ਹੋ, ਤਾਂ ਨਿਮਨ ਨੂੰ ਕਾਲ ਕਰੋ:

- Medicare ਨੂੰ 1-800-MEDICARE (1-800-633-4227) 'ਤੇ। ਤੁਸੀਂ ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ। TTY ਉਪਭੋਗਤਾਵਾਂ ਨੂੰ 1-877-486-2048 'ਤੇ ਕਾਲ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ।
- Medi-Cal ਸਿਵਲ ਅਧਿਕਾਰਾਂ ਦੇ ਦਫ਼ਤਰ ਨੂੰ 916-440-7370 'ਤੇ। TTY ਉਪਭੋਗਤਾਵਾਂ ਨੂੰ 711 'ਤੇ ਕਾਲ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ।
- ਅਮਰੀਕੀ ਸਿਹਤ ਅਤੇ ਮਨੁੱਖੀ ਸੇਵਾਵਾਂ ਵਿਭਾਗ, ਸਿਵਲ ਅਧਿਕਾਰਾਂ ਦੇ ਦਫ਼ਤਰ ਨੂੰ 1-800-368-1019 'ਤੇ। TTY ਉਪਭੋਗਤਾਵਾਂ ਨੂੰ 1-800-537-7697 'ਤੇ ਕਾਲ ਕਰਨੀ ਚਾਹੀਦੀ ਹੈ।



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. Ваше право на получение услуг и информации удобным для вас способом

Мы обязаны обеспечить, чтобы **все** услуги — как клинические, так и неклинические — предоставлялись вам с учетом культурных особенностей и в доступной форме, в том числе лицам с ограниченным знанием английского языка, ограниченными навыками чтения, нарушениями слуха, а также представителям различных культурных и этнических групп. Мы также обязаны предоставлять вам информацию о льготах, доступных вам в рамках нашего плана, и ваших правах в понятной и доступной вам форме. Мы должны уведомлять вас о ваших правах ежегодно, пока вы являетесь участником нашего плана.

- Чтобы получить информацию в понятной и доступной для вас форме, позвоните в отдел обслуживания участников. У нас есть устные переводчики, которые на различных языках отвечают на вопросы участников плана.
- Наш план также может предоставить вам материалы на других языках, помимо английского, включая арабский, армянский, камбоджийский (кхмерский), китайский язык (упрощенное письмо), китайский язык (традиционное письмо), фарси, хинди, хмонг, японский, корейский, лаосский, мьянмарский, панджаби, русский, испанский, тагальский, тайский, украинский и вьетнамский, и в других форматах, например напечатанные крупным шрифтом, шрифтом Брайля или в виде аудиозаписи. Чтобы получить материалы в одном из этих альтернативных форматов, позвоните в отдел обслуживания участников или напишите по адресу Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- Этот документ можно бесплатно получить на других языках и в других форматах, например напечатанный крупным шрифтом, шрифтом Брайля или в виде аудиозаписи. Позвоните в отдел обслуживания участников по номеру, указанному в нижней части страницы. Во время разговора с нашим сотрудником попросите считать ваше распоряжение долгосрочным. В таком случае мы будем ежегодно присылать вам документы на выбранном языке и в выбранном формате.
- Позвоните в отдел обслуживания участников по номеру, указанному в нижней части этой страницы, чтобы изменить или отменить ваши долгосрочные распоряжения. Кроме того, необходимые документы можно найти на веб-сайте www.anthem.com/ca.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Если при получении информации от представителей нашего плана вы испытываете трудности, связанные с языком ее изложения или по причине инвалидности, и хотите подать жалобу, вы можете позвонить:

- В программу Medicare по номеру 1-800-MEDICARE (1-800-633-4227). Вы можете звонить по этому номеру круглосуточно и в любой день недели. Пользователям ТТУ следует звонить по номеру 1-877-486-2048.
- В отдел гражданских прав программы Medi-Cal по номеру 916-440-7370. Пользователям ТТУ следует звонить по номеру 711.
- В Управление по гражданским правам Министерства здравоохранения и социальных служб США по номеру 1-800-368-1019. Пользователям ТТУ следует звонить по номеру 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

Debemos asegurarnos de que le proporcionen **todos** los servicios, tanto clínicos como no clínicos, de una forma culturalmente adecuada y accesible, incluso para aquellos con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva u orígenes étnicos y culturales diversos. 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, incluidos árabe, armenio, camboyano (jemer), chino simplificado, chino tradicional, farsi, hindi, hmong, japonés, coreano, laosiano, mien, punjabí, ruso, español, tagalo, tailandés, ucraniano y vietnamita, y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Miembros o escriba a Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- 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 enviaremos los mismos documentos en el formato e idioma solicitados todos los años.
- Llame a Servicios para Miembros al número que figura en la parte inferior de esta página para cambiar o cancelar el pedido regular. También puede encontrar los documentos en línea en www.anthem.com/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 de Medi-Cal al 916-440-7370. Los usuarios de TTY deben llamar al 711.
- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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

Dapat nating tiyakin **lahat** ang mga serbisyo, parehong klinikal at hindi klinikal, ay ibinibigay sa iyo sa paraang may kakayahang pangkultura at naa-access kabilang ang para sa mga may limitadong kasanayan sa Ingles, limitadong kasanayan sa pagbabasa, kawalan ng kakayahan sa pandinig, o sa mga may magkakaibang kultura at etnikong pinagmulan. Dapat din naming sabihin sa iyo ang tungkol sa mga benepisyo ng aming plan at ang iyong mga karapatan sa paraang mauunawaan mo. Dapat naming sabihin sa iyo ang tungkol sa iyong mga karapatan sa bawat taon na ikaw ay nasa aming plan.

- Upang makakuha ng impormasyon sa paraang mauunawaan mo, tawagan ang Mga Serbisyo sa Miyembro. Ang aming plan 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 materyal sa mga wika maliban sa Ingles kabilang ang Arabic, Armenian, Cambodian (Khmer), Chinese Simplified, Chinese Traditional, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian at Vietnamese at sa mga format tulad ng malalaking print, braille, o audio. Upang makakuha ng mga materyales sa isa sa mga alternatibong format na ito, mangyaring tumawag sa Mga Serbisyo sa Miyembro o sumulat sa Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- Makukuha mo ang dokumentong ito nang libre sa iba pang wika at format tulad ng malalaking letra, braille, o audio. Tumawag sa Mga Serbisyo sa Miyembro sa numerong nakalista sa ibaba ng pahinang ito. Kapag tumawag, 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.
- Tumawag sa Mga Serbisyo sa Miyembro sa numerong nakalista sa ibaba ng page na ito para baguhin o kanselahin ang isang standing order. Maaari mo ring mahanap ang iyong mga dokumento online sa www.anthem.com/ca.

Kung nahihirapan kang makakuha ng impormasyon mula sa aming plan 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.
- Tanggapan ng Mga Karapatang Sibil ng Medi-Cal sa 916-440-7370. Ang mga gumagamit ng TTY ay dapat tumawag sa 711.
- Kagawaran ng Kalusugan at mga Serbisyong Pantao ng U.S., Tanggapan para sa mga Karapatang Sibil sa 1-800-368-1019. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. สิทธิของคุณในการได้รับบริการและข้อมูลในลักษณะที่ตรงกับความต้องการของคุณ

เราต้องทำให้แน่ใจว่าบริการทั้งหมด ทั้งทางคลินิกและไม่ใช้ทางคลินิกที่ให้บริการแก่คุณนั้นคำนึงถึงวัฒนธรรมและทุกคนสามารถเข้าถึงได้ ซึ่งรวมถึงผู้ที่มีทักษะภาษาอังกฤษจำกัด ผู้ที่มีทักษะการอ่านจำกัด ผู้ที่มีความบกพร่องทางการได้ยิน หรือผู้ที่มีภูมิหลังทางวัฒนธรรมและชาติพันธุ์ที่หลากหลาย เราต้องแจ้งให้คุณทราบเกี่ยวกับสิทธิประโยชน์ของแผนและสิทธิต่างๆ ของคุณในรูปแบบที่คุณเข้าใจได้ เราต้องแจ้งให้คุณทราบเกี่ยวกับสิทธิของคุณในแต่ละปีที่คุณอยู่ในแผนของเรา

- หากต้องการรับข้อมูลในรูปแบบที่คุณเข้าใจได้ โปรดติดต่อฝ่ายบริการสมาชิก แผนของเรามีบริการล่ามฟรีสำหรับตอบคำถามในภาษาต่างๆ
- แผนของเรายังมีเอกสารในภาษาอื่นนอกเหนือจากภาษาอังกฤษให้บริการแก่คุณ ได้แก่ ภาษาอาหรับ ภาษาอาร์เมเนีย ภาษากัมพูชา (เขมร) จีน (ตัวย่อ) จีน (ตัวเต็ม) ภาษาเปอร์เซีย ภาษาฮินดี ภาษาฮังการี ภาษาญี่ปุ่น ภาษาเกาหลี ภาษาลาว ภาษาเมียนมา ภาษาญิบรอลตาร์ ภาษาโรมาเนีย ภาษาสเปน ภาษาตากาล็อก ภาษาไทย ภาษายูเครน และภาษาเวียดนามในรูปแบบตัวอักษรขนาดใหญ่ อักษรเบรลล์ หรือเสียง หากต้องการรับเอกสารในรูปแบบทางเลือกเหล่านี้ โปรดติดต่อฝ่ายบริการสมาชิก หรือส่งจดหมายไปที่ Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007
- คุณสามารถรับเอกสารนี้ได้ฟรีในภาษาและรูปแบบอื่นๆ เช่น ตัวอักษรขนาดใหญ่ อักษรเบรลล์ หรือเสียงติดต่อฝ่ายบริการสมาชิก ตามหมายเลขที่ระบุไว้ด้านล่างของหน้านี้ เมื่อคุณติดต่อเรา โปรดแจ้งให้เราทราบหากคุณต้องการให้รูปแบบเอกสารที่คุณเลือกเป็นรูปแบบที่ใช้ประจำ ซึ่งหมายความว่าเราจะส่งเอกสารชุดเดียวกันในรูปแบบและภาษาที่คุณต้องการทุกปี
- ติดต่อฝ่ายบริการสมาชิก ตามหมายเลขที่ระบุไว้ด้านล่างของหน้านี้เพื่อเปลี่ยนแปลงหรือยกเลิกรูปแบบที่ใช้ประจำ คุณสามารถค้นหาเอกสารของคุณทางออนไลน์ได้ที่ www.anthem.com/ca

หากคุณประสบปัญหาในการเข้าถึงข้อมูลจากแผนของเราเนื่องจากข้อจำกัดทางภาษาหรือความพิการและต้องการยื่นเรื่องร้องเรียน โปรดติดต่อ:

- Medicare ที่ 1-800-MEDICARE (1-800-633-4227) คุณสามารถติดต่อได้ทุกวันตลอด 24 ชั่วโมง ผู้ใช้ TTY ควรโทรไปที่ 1-877-486-2048
- สำนักงาน Medi-Cal ของสำนักสิทธิพลเมืองที่ 916-440-7370 ผู้ใช้ TTY ควรโทรไปที่ 711
- สำนักสิทธิพลเมือง กระทรวงสุขภาพและบริการมนุษย์สหรัฐฯ ที่ 1-800-368-1019 ผู้ใช้ TTY ควรโทรไปที่ 1-800-537-7697



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. Ваше право на отримання послуг та інформації зручним для вас способом

Ми зобов'язані забезпечити, щоб **усі** послуги — як клінічні, так і неклінічні — надавалися вам з урахуванням культурних особливостей та в доступній формі, зокрема особам з обмеженим знанням англійської мови, обмеженими навичками читання, порушеннями слуху, а також представникам різних культурних та етнічних груп. Ми також зобов'язані надавати вам інформацію про пільги, доступні вам у межах нашого плану, і ваші права у зрозумілій та доступній вам формі. Ми повинні повідомляти вас про ваші права щорічно, доки ви є учасником нашого плану.

- Щоб отримати інформацію у зрозумілій та доступній для вас формі, зателефонуйте до відділу обслуговування учасників. У нас є усні перекладачі, які різними мовами відповідають на запитання учасників плану.
- Наш план також може надати вам матеріали іншими мовами, крім англійської, включаючи арабську, вірменську, камбоджійську (кхмерську), китайська мова (спрощене письмо), китайська мова (традиційне письмо), фарсі, хінді, хмонг, японську, корейську, лаоську, м'єнську, пенджабі, російську, іспанську, тагальську, тайську, українську та в'єтнамську, а також в інших форматах, наприклад, надруковані великим шрифтом, шрифтом Брайля або у вигляді аудіозапису. Щоб отримати матеріали в одному з цих альтернативних форматів, зателефонуйте до відділу обслуговування учасників або напишіть на адресу Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- Цей документ можна безкоштовно отримати іншими мовами та в інших форматах, наприклад надрукований великим шрифтом, шрифтом Брайля або у вигляді аудіозапису. Зателефонуйте до відділу обслуговування учасників за номером, вказаним у нижній частині сторінки. Під час розмови з нашим працівником попросіть уважати ваше розпорядження довгостроковим. У такому разі ми щорічно надсилатимемо вам документи вибраною мовою та у вибраному форматі.
- Зателефонуйте до відділу обслуговування учасників за номером, вказаним у нижній частині цієї сторінки, щоб змінити або скасувати ваші довгострокові розпорядження. Крім того, необхідні документи можна знайти на вебсайті www.anthem.com/ca.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Якщо під час отримання інформації від представників нашого плану ви відчуваєте труднощі, пов'язані з мовою її викладу або через інвалідність, і хочете подати скаргу, ви можете зателефонувати:

- До програми Medicare за номером 1-800-MEDICARE (1-800-633-4227). Ви можете телефонувати за цим номером цілодобово та в будь-який день тижня. Користувачам ТТҮ слід телефонувати за номером 1-877-486-2048.
- До відділу цивільних прав програми Medi-Cal за номером 916-440-7370. Користувачам ТТҮ слід телефонувати за номером 711.
- До Управління з цивільних прав Міністерства охорони здоров'я та соціальних служб США за номером 1-800-368-1019. Користувачам ТТҮ слід телефонувати за номером 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 rằng **tất cả** dịch vụ, cả lâm sàng và phi lâm sàng, đều được cung cấp cho quý vị theo cách phù hợp về mặt văn hóa và dễ tiếp cận, bao gồm cả cho những người có trình độ Tiếng Anh hạn chế, kỹ năng đọc hạn chế, khiếm thính hoặc những người có nền tảng văn hóa và dân tộc đa dạng. 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 bao gồm Tiếng Ả Rập, Tiếng Armenia, Tiếng Campuchia (Khmer), Tiếng Trung Giản thể, Tiếng Trung Phồn thể, Tiếng Farsi, Tiếng Hindi, Tiếng Hmong, Tiếng Nhật, Tiếng Hàn, Tiếng Lào, Tiếng Miên, Tiếng Punjabi, Tiếng Nga, Tiếng Tây Ban Nha, Tiếng Tagalog, Tiếng Thái, Tiếng Ukraina và Tiếng Việt 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 cho Ban Dịch vụ Thành viên hoặc viết thư gửi đến Anthem Full Dual Advantage Aligned (HMO D-SNP) P.O. Box 60007, Los Angeles, CA 90060-0007.
- 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. Hãy gọi cho 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 hàng năm chúng tôi sẽ gửi các tài liệu tương tự theo định dạng và ngôn ngữ yêu cầu.
- Gọi cho Ban Dịch vụ Thành viên theo số điện thoại được liệt kê ở cuối trang này để thay đổi hoặc hủy lệnh thường trực. Quý vị cũng có thể tìm tài liệu của mình trực tuyến tại www.anthem.com/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.
- Văn phòng Dân quyền Medi-Cal theo số 916-440-7370. Người dùng TTY xin gọi 711.
- Bộ Y tế và Dịch vụ Nhân sinh Hoa Kỳ, Văn phòng Dân quyền theo số 1-800-368-1019. Người dùng TTY xin gọi 1-800-537-7697.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *Member Handbook*.
 - Call Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You 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 isn't your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
 - This includes the right to get timely services from specialists.
 - If you 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's urgently needed without prior authorization (PA).
- 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 this *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 this *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 PHI as required by federal and state laws.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Your PHI includes the personal 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 when it comes to your information and controlling how your PHI is used. We provide you with a written notice that advises 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 aren't required to get any other member's authorization to receive sensitive services or to submit a claim for sensitive services. Anthem Full Dual Advantage Aligned (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 Full Dual Advantage Aligned (HMO D-SNP) won't disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Anthem Full Dual Advantage Aligned (HMO D-SNP) will accommodate requests for confidential communication in the form and format requested, if it's 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.

Members will be given details about the confidential communication request process when they enroll in or renew a plan. They can also submit a Confidential Communications of Medical Information (CCMI) request by calling the Member Services toll free number on their Member ID card. The plan will honor their request until the member asks for it to be changed. The plan will send a confirmation letter to the member to let them know their confidential communications request was received. The member can ask for the status of their request by contacting the plan.

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 may release PHI if ordered by a court, but only if it is allowed by California law.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 share your PHI with others for any purposes that aren't routine.

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

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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- o 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**
 - o To help doctors, hospitals and others get you the care you need
- **For payment, healthcare operations and treatment**
 - o To share information with the doctors, clinics and others who bill us for your care
 - o 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 www.anthem.com/ca for more information.

- **For healthcare business reasons**
 - o To help with audits, fraud and abuse prevention programs, planning, and everyday work
 - o To find ways to make our programs better
- **For public health reasons**
 - o To help public health officials keep people from getting sick or hurt
 - o With others who help with or pay for your care
 - o With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
 - o 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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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.



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- 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 **1-833-897-1342**. 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 **1-833-897-1342** (TTY **711**).



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Revised June 2022.

C3. Notice of Privacy Practices

Below is the Notice of Privacy Practices as of August 2026.

Notice of privacy practices

Important information about your rights and our responsibilities

Protecting your personal health information is important. Each year, we're required to send you specific information about your rights and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online or on your mobile app? Go to www.anthem.com/ca and sign up to get these notices by email.

State notice of privacy practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your ID card for more details.

Your personal information

Your nonpublic (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company – without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt



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out, we'll let you know, and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

THIS NOTICE DESCRIBES HOW MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

HIPAA notice of privacy practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your protected health information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for healthcare you get through your plan.

Healthcare operations: We collect, use and share PHI for our healthcare operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use PHI with technology to support and enable services provided to you.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- We may also use and share PHI directly or indirectly with health information exchanges for payment, healthcare operations and treatment. If you don't want your PHI to be shared in these situations, visit [anthem.com/privacy](https://www.anthem.com/privacy) for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways - usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
 - o Preventing disease
 - o Helping with product recalls
 - o Reporting adverse reactions to medicines



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- o Reporting suspected abuse neglect or domestic violence
- o Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.
- Responding to the Secretary of Human Health Services for HIPAA rules compliance and enforcement purposes.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity, language, disability status, sexual orientation and gender identity: We may collect, infer, receive and/or maintain race, ethnicity, language, disability status, sexual orientation and gender identity information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity, language, disability status, sexual orientation and gender identity information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Please note Elevance Health and its subsidiaries comply with Executive Order 14168.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by



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unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.

- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or healthcare operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
- Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and information practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws



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HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA. One example is with Substance Use Disorder (SUD) Information we may receive from Providers or programs regulated by federal law (42 CFR Part 2). All disclosures of such SUD information must comply with applicable Federal and State privacy laws, including 42 CFR Part 2. We are allowed to Use and Disclose SUD information for certain Treatment, Payment, and Health Care Operations activities. You have the right to consent to the disclosure of SUD information in certain circumstances. You can revoke this consent in writing at any time.

Your Part 2 SUD records (or someone's testimony about what those records say) cannot be used or shared in a case against you in civil, criminal, administrative, or legislative proceedings unless:

- You give written permission, or
- A court orders the disclosure and the order is accompanied by a subpoena or similar legal requirement, and you (or the person holding your SUD records) are given notice and a chance to speak to the court before the records are shared.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at www.anthem.com/privacy.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call 1-844-203-3796 to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision is as of August 2026 as noted at the top of this sub-section.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prosthesis and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

You'll pay your usual deductible, copay and/or coinsurance. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at <http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra>.

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 Member Services. This is a free service to you. You can call Member Services and ask to have this information sent to you in Arabic, Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian and Vietnamese. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
 - o financial information
 - o how plan members have rated us



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- o the number of appeals made by members
- o how to leave our plan
- Our network providers and our network pharmacies, including:
 - o how to choose or change primary care providers
 - o qualifications of our network providers and pharmacies
 - o how we pay providers in our network
- Covered services and drugs, including:
 - o services (refer to **Chapters 3 and 4** of this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
 - o limits to your coverage and drugs
 - o rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
 - o put in writing why something isn't covered
 - o change a decision we made
 - o pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't 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 this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook*:



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- o For more information about when you can join a new MA or drug benefit plan.
- o For information about how you'll 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 all 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 won't 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 this *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

Sometimes people can't 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** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you **don't** want.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 aren't 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 social worker, or some office supply stores. 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. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** 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 if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
 - o The hospital will ask if you have a signed advance directive form and if you have it with you.
 - o 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 Full Dual Advantage Aligned (HMO D-SNP) will tell you about changes to the state law no later than 90 days after the change.

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. 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



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *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 **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.
- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. For more details about HICAP, refer to **Chapter 2**.
- The Medi-Cal Ombudsman at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at <https://www.medicare.gov/publications/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 this *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 this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- o Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or 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're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
 - o 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.
 - o Make sure your doctors and other providers know about all the drugs you take. This includes drugs, over-the-counter drugs, vitamins, and supplements.
 - o 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 other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - o Medicare Part A and Medicare Part B premiums. For most Anthem Full Dual Advantage Aligned (HMO D-SNP) members, Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.
 - o **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
 - o **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* advises you about our service area.
 - o 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 drug plan in your new location. We can tell you if we have a plan in your new area.
 - o Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Medi-Cal.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- **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.
- **If you move, tell Social Security (or the Railroad Retirement Board).**
- **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.**



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

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 our plan.
- You need a service, item, or medication that our plan said it won't pay for.
- You disagree with a decision our 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're 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 Medicare Medi-Cal Ombudsman Program at 1-855-501-3077 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombudsman 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*.

Table of Contents

A. What to do if you have a problem or concern.....	211
A1. About the legal terms	211
B. Where to get help.....	211
B1. For more information and help.....	211
C. Understanding Medicare and Medi-Cal complaints and appeals in our plan	213
D. Problems with your benefits	213
E. Coverage decisions and appeals.....	213
E1. Coverage decisions	214
E2. Appeals.....	214
E3. Help with coverage decisions and appeals.....	214
E4. Which section of this chapter can help you	215
F. Medical care	216
F1. Using this section.....	216
F2. Asking for a coverage decision	217



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F3. Making a Level 1 Appeal.....	219
F4. Making a Level 2 Appeal.....	222
F5. Payment problems	227
G. Medicare Part D drugs.....	228
G1. Medicare Part D coverage decisions and appeals	228
G2. Medicare Part D exceptions.....	229
G3. Important things to know about asking for an exception.....	230
G4. Asking for a coverage decision, including an exception.....	231
G5. Making a Level 1 Appeal.....	233
G6. Making a Level 2 Appeal	235
H. Asking us to cover a longer hospital stay.....	236
H1. Learning about your Medicare rights	237
H2. Making a Level 1 Appeal.....	238
H3. Making a Level 2 Appeal	239
I. Asking us to continue covering certain medical services.....	240
I1. Advance notice before your coverage ends	241
I2. Making a Level 1 Appeal.....	241
I3. Making a Level 2 Appeal	242
J. Taking your appeal beyond Level 2.....	243
J1. Next steps for Medicare services and items.....	243
J2. Additional Medi-Cal appeals.....	244
J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests.....	245
K. How to make a complaint.....	246
K1. What kinds of problems should be complaints.....	246
K2. Internal complaints	248
K3. External complaints.....	248



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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” (IRO) instead of “Independent Review Entity” (IRE)

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 our plan

You can call our plan at 1-833-897-1342 to help deal with a problem or answer questions.

Help from the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. You can also review their website at <https://www.aging.ca.gov/hicap/>. HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn't connected with us or



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 Medicare Medi-Cal Ombudsman Program

You can call the Medicare Medi-Cal Ombudsman Program and speak with an advocate about your health coverage questions. They may be able to offer free legal help. The Ombudsman Program isn't connected with us or with any insurance company or health plan. Their phone number is 1-855-501-3077, 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). TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.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 (DMHC) for free help. The DMHC is responsible for overseeing 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**. You can also visit DMHC's website at www.dmhc.ca.gov.

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 **1-833-897-1342** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

impaired. The department’s internet website www.dmh.ca.gov has complaint forms, IMR application forms and instructions online.

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 your Medicare and Medi-Cal managed care benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes can't 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 following chart 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 (medical items, services and/or Part B drugs) are covered or not, the way they're covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to Section E , “Coverage decisions and appeals.”	No. My problem isn't 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 for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

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. 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'll cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision when we review a request for service or a claim. In some cases, we may decide a service or drug isn't 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 aren't 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 your health problem is urgent or involves an immediate and serious threat to your health, or if you're in severe pain and need a faster decision, you may ask for an IMR Medical Review from the Department of Managed Health Care at www.dmhca.ca.gov. Refer to **Section F4** 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 part or all of what you asked for, we'll send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals.

If you aren't 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- **Medicare Medi-Cal Ombudsman Program at 1-855-501-3077.**
- **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 helps people with appeals regarding 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**. You can also visit DMHC's website at www.dmhca.gov. While the DMHC can help people in Managed Medi-Cal plans, it can't help people in Medicare plans only and in the following County Organized Health Systems (COHS): Partnership Health Plan, Gold Coast Health Plan, CenCal Health, Central California Alliance for Health, and CalOptima. The federal government regulates Medicare, plans, and the Department of Health Care Services regulates COHS plans.
- **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 aren't required to have a lawyer** to ask for a coverage decision or make an appeal.
 - o 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.
 - o Ask for a legal aid attorney from the Medicare Medi-Cal Ombudsperson Program at 1-855-501-3077.

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. **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 drugs”
- **Section H**, “Asking us to cover a longer hospital stay”



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- **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 our share of the cost of your care. For information about requesting a longer hospital stay, please refer to **Section H**.

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B 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 aren't 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 won't 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.

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 CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

6. You're experiencing delays in care or you can't find a doctor.

What you can do: You can file a complaint. Refer to **Section K2**.

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: 1-833-897-1342 (TTY: 711).
- faxing: 1-877-664-1504.
- writing:
Anthem Blue Cross
Coverage Determinations
P.O. Box 60007
Los Angeles, CA 90060-0007

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 within:

- **Five business days, and no later than seven calendar days** after we get your request **for a medical service or item that's subject to our prior authorization rules.**
- **Five business days, and no later than 14 calendar days** after we get your request **for all other medical services or items.**
- **72 hours** after we get your request **for a Medicare Part B drug.**

For a medical item or service, we can take up to 14 more calendar days if we 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'll tell you in writing. **We can't take extra days if your request is for a Medicare Part B drug.**

If you think we **shouldn't** 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



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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 that requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we’ll give you an answer within:

- **72 hours** after we get your request **for a medical service or item**.
- **24 hours** after we get your request **for a Medicare Part B drug**.

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’ll tell you in writing. **We can’t take extra time if your request is for a Medicare Part B drug.**

If you think we **shouldn’t** 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’ll call you as soon as we make the decision.

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

- You’re asking for coverage for medical items and/or services that you **didn’t get**. You can’t ask for a fast coverage decision about payment for items or services 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 have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

- If you decide to make an appeal, you'll 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'll 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 related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your authorized representative must contact us. Call us at 1-833-897-1342.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-833-897-1342.

- If your doctor or other provider asks to continue a service or item you're 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.
- 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 before our deadline for making a decision on your appeal:
 - We dismiss your request, and
 - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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, you and/or your doctor can request a fast appeal.

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

- If we decide that your health doesn’t meet the requirements for a fast appeal, 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 appeal if your doctor asks for it.
 - How you can file a “fast complaint” about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we’re 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 ten 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’ll get the service or item with no changes while your Level 1 appeal is pending.
 - You’ll also get all other services or items (that aren’t the subject of your appeal) with no changes.
 - If you don’t appeal before these dates, then your service or item won’t 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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, or sooner if your health requires a quicker response.** If we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.
 - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. 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, or sooner if your health requires it.
- **If we say No to part or all of your request,** we send your appeal to the IRO 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 drug you didn't get, we give you our answer **within seven 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 IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 - State Hearing with the state yourself as soon the time is up. In California a State Hearing is called State Hearing. To file a State Hearing, refer to page 221, as applicable.

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 of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within seven calendar days of the date we got your appeal if your request is for a Medicare Part B drug.

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 IRO 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we'll 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.
- 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 IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review isn't available if you have already presented evidence in a State Hearing.

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 IRO.
- If your problem is about a service usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within ten calendar days after getting our decision letter.

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

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the Independent Review Organization (IRO) 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 IRO, 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 IRO additional information to support your appeal.
- Reviewers at the IRO 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 have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO 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 IRO 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 drug, the IRO must give you an answer to your Level 2 Appeal **within seven calendar days** of getting your appeal.

If the IRO gives you their answer in writing and explains the reasons.

- **If the IRO 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 **five working days** after we get the IRO's decision for **standard requests, or**
 - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:**
 - **Within 72 hours** after we get the IRO's decision for **standard requests, or**
 - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal**, it means they agree that we shouldn't 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 (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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) Department of Managed Health Care (DMHC)

You can file a complaint with or apply for an Independent Medical Review (IMR) from the Help Center at the DMHC. By filing a complaint, the DMHC will review our decision. The DMHC will do their own investigation of your complaint or decide whether the case qualifies for IMR. An IMR may be available for any Medi-Cal covered service or item that's medical in nature. An IMR is a review of your case by experts who aren't 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's not medically necessary.
- Won't cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- Won't pay for emergency or urgent Medi-Cal services that you already received.
- Hasn't resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours, or sooner, if your health requires it, for a fast appeal.

In most cases, you must file an appeal with us before requesting an IMR. Refer to **Section G5** for information about our Level 1 appeal process. If you disagree with our decision, you can submit an IMR Application/Complaint Form with the DMHC.

NOTE: If your provider filed an appeal for you, but we don't get your Appointment of Representative form, you'll need to refile your appeal with us before you can file for a Level 2 IMR with the DMHC unless your appeal involves an imminent and serious threat to your health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function.

You may request for an IMR and a State Hearing, but you aren't allowed to go to IMR if you have already presented evidence in a State Hearing or had a State Hearing on the same issue.

If your treatment was denied because it was experimental or investigational, you don't 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're in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

You must **apply for an IMR within six months** after we send you a written decision about your appeal. The DMHC may accept your application after six months for good reason, such as you had a medical condition that prevented you from asking for the IMR within six months, or you didn't get adequate notice from us of the IMR process.

To file a complaint or ask for an IMR:

- Fill out the IMR/Complaint Form available at: www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.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 can't 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**.
- Submit the IMR/Complaint Form and any attachments to the DMHC online: www.dmhc.ca.gov/FileaComplaint

Submit by mail or fax:

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

Within seven days, DMHC will review your application and send you an acknowledgment of receipt letter. If DMHC determines the case qualifies for IMR, then an IMR decision will be made within 45 days after the receipt of all required documentation.

If your case is urgent and you qualify for IMR, an IMR decision will usually be made within seven days after the receipt of all required documentation.

If you're not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC doesn't receive all of the medical records needed from you or your treating doctor. If you're using a doctor who isn't in your health plan's network, it's 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 isn't 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

(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 won't approve, or we won't 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 "Appeal Decision Letter" 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 229 for more information.

You can ask for a State Hearing in the following ways:

- Online at www.cdss.ca.gov.
- By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.
- In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:
- Mail: California Department of Social Services State Hearings Division P.O. Box 944243, Mail Station 9-17-433 Sacramento, CA 94244-2430
- Fax: (916) 309-3487 or toll-free at 1-833-281-0903
- You may complete the "Request for State Hearing" on the back of the notice of action. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

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 State Hearings Division gives you their decision in writing and explains the reasons.

- If the State Hearings Division 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 State Hearings Division says **No** to part or all of your appeal, it means they agree that we shouldn't 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

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

The letter you get from the State Hearings Division describes the next appeal option.

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

F5. Payment problems

We don't 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're never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or items.

For more information, refer to **Chapter 7** of this *Member Handbook*. It describes situations when you may need to ask us to pay you 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're asking for a coverage decision. We'll 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'll send your provider the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we'll 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 isn't covered or you didn't follow all the rules, we'll 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 our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll send your case to the IRO. We'll send you a letter if this happens.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- If the IRO 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 IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll 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. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many 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 Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medi-Cal follow the process in **Section E**.

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 this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

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

- You ask us to make an exception, including asking us to:
 - Cover a Medicare Part D drug that isn't 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 Medicare 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 have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 <i>Drug List</i> or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our <i>Drug List</i> , 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. Medicare 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 isn't on our *Drug List*

- If we agree to make an exception and cover a drug that's not on our *Drug List*
- 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 this *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
 - o Being required to use the generic version of a drug instead of the brand name drug.
 - o Getting our approval in advance before we agree to cover the drug for you. This is sometimes called “prior authorization (PA).”
 - o Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called “step therapy.”
 - o Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you’re required to pay.

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 **don’t** approve your exception request. If you ask us for a tiering exception, we generally **don’t** 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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. Please 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 this *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're 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'll review your request under the fast coverage decision timeline. We'll send you a letter with this information.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we'll decide if you get a fast coverage decision.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we'll use the standard deadlines instead.
 - We send you a letter that tells you we'll use the standard deadline. The letter also tells you how to make an appeal 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 IRO. 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 IRO.
- 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 IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- **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 Medicare Part D drug coverage decision is called a plan **“redetermination”**.

- Start your **standard** or **fast appeal** by calling 1-833-897-1342, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 IRO 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 seven 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 seven calendar days, we must send your request to Level 2 of the appeals process. Then an IRO 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 seven 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 IRO 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 **IRO** 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" (IRO) 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 IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. 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 IRO, 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.** If you need help requesting a free copy of your case file, call 1-833-897-1342.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO 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 IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within seven 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO 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 IRO 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 IRO 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 IRO 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 IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ 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 this *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're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Notwithstanding the appeals discussed in this **Section H**, 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** 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.

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). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO 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 aren't part of our plan.

In California, the QIO is Commence Health Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). Call them at 1-877-588-1123, Monday through Friday from 9:00 a.m. to 5:00 p.m. local time. Weekends and holidays 10:00 a.m. to 4:00 p.m. local time for appeals. Additionally, 24 hour voicemail service is available. TTY users should dial 711. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO 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 QIO's decision about your appeal.
- **If you don't 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.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization won't 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're 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** 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 QIO 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 QIO 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that's 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). (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Within one full day after getting all of the information it needs, the QIO gives you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO 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 QIO 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 QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO 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 QIO 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 QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO 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 QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO 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** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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, **and**
- rehabilitation care as an outpatient at a Medicare-approved 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 HICAP at 1-800-434-0222.
- **Contact the QIO.**
 - Refer to **Section H2** or refer to **Chapter 2** of this *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 QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If the Quality Improvement Organization won't 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're 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** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

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). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO 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 provide their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying 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 CORF services after the date your coverage ends.
- You decide if you want to continue these services and make a Level 2 Appeal.

13. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO 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 QIO 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.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for 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 QIO 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** 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 ALJ 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 doesn't meet a certain minimum dollar amount, you can't appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO 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 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 you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 (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'll 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 State Hearings Division 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 Medicare Part D Drug Requests

This section may be right for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals were 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 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 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

- 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 or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the 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 about 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're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't 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're being pushed out of our plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Complaint	Example
Accessibility and language assistance	- You can't physically access the health care services and facilities in a doctor or provider's office. - Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). - Your provider doesn't 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 isn't clean.
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 IRO 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 1-833-897-1342.

The legal term for "complaint" is "**grievance.**"

The legal term for "making a complaint" is "**filing a grievance.**"



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

K2. Internal complaints

To make an internal complaint, call Member Services at 1-833-897-1342. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there's 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'll 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'll 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'll 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/my/medicare-complaint. You don't need to file a complaint with Anthem Full Dual Advantage Aligned (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 questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

If you have any other feedback or concerns, or if you feel the health plan isn't addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users 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 a.m. and 5 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. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan has not resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal 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 (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR 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 OCR 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 (ADA) 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 California's DHCS Office of 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 www.dhcs.ca.gov/services/MH/Pages/mh-ombudsman.aspx.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

QIO

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 QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 QIO, refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook*.

In California, the QIO is called Commence Health. The phone number for Commence Health is 1-877-588-1123.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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'll still be in the Medicare and Medi-Cal programs as long as you're eligible. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

Table of Contents

A. When you can end your membership in our plan.....	252
B. How to end membership in our plan	253
C. How to get Medicare and Medi-Cal services separately	253
C1. Your Medicare services	253
C2. Your Medi-Cal services.....	257
D. Your medical items, services and drugs until your membership in our plan ends	257
E. Other situations when your membership in our plan ends.....	258
F. Rules against asking you to leave our plan for any health-related reason	259
G. Your right to make a complaint if we end your membership in our plan.....	259
H. How to get more information about ending your plan membership	259



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca. 251

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you have some choices to end your membership with our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- **The Open 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 (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. 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're eligible to make a change to your enrollment. For example, when:

- you move 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 facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, 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 options and services in **Section C2**.

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

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). 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 a.m. to 5 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,



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Monday through Friday from 800 a.m. to 6 p.m. TTY users should call 1-800-430-7077. Or visit www.healthcareoptions.dhcs.ca.gov/en.

- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8 a.m. to 5 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* for information about drug management programs.

B. How to end membership in our plan

If you decide to end your membership you can do so by enrolling in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 260.
- 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 separately

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 any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

1. You can change to:

A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It's for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.

Note: The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California.

Here is what to do:

Call Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For Program of All-Inclusive Care for the Elderly (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 a.m. to 5 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 Medi-Medi Plan.

You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins.

Your Medi-Cal plan will change to match your Medi-Medi Plan.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

2. You can change to: Original Medicare with a separate Medicare drug plan, and a Medi-Cal Plan.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). 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 a.m. to 5 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 drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.
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If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

3. You can change to: Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason. NOTE: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop 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 a.m. to 5 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). 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 a.m. to 5 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain enrolled in your Medi-Cal Plan unless you choose a different plan.
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4. You can change to: Any Medicare health plan during certain times of the year including the Open Enrollment Period and the Medicare Advantage Open Enrollment Period or other situations described in Section A.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (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 a.m. to 5 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'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal Plan may change.
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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. Or visit www.healthcareoptions.dhcs.ca.gov/en. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. Your medical items, 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 drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.

- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in Anthem Full Dual Advantage Aligned (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're 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's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. Note: if you no longer qualify for Medi-Cal you can temporarily continue in our plan with Medicare benefits, please see information below on deeming period.
- If you move out of our service area.
- If you're away from our service area for more than six months.
 - o 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.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
 - o You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.
 - o The Centers for Medicare & Medicaid Services (CMS) will notify us if you're not eligible to remain a member on this basis.
 - o We must disenroll you if you don't meet this requirement.

If you lose your Medi-Cal eligibility but can be expected to regain it within the six month period of deemed continued eligibility, we'll continue to provide all Medicare benefits covered by Anthem Full Dual Advantage Aligned (HMO D-SNP). When your Medi-Cal coverage ends, we won't pay for your Medi-Cal benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medi-Cal used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.

In addition, if you lose your Medi-Cal eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

For additional information about how a change in your Medi-Cal eligibility may affect your benefits and cost sharing, please contact Member Services.

We'll assist you to regain your Medi-Cal eligibility. If your Medi-Cal eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Medi-Cal benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and cost-sharing assistance for which you again qualify. If you can't regain Medi-Cal within six months we'll disenroll you from Anthem Full Dual Advantage Aligned (HMO D-SNP). If you regain Medi-Cal eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

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're enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (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 can't 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.

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 this *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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 this *Member Handbook*.

Table of Contents

A. Notice about laws	261
B. Federal notice about nondiscrimination	261
C. Notice about nondiscrimination for Medi-Cal.....	261
D. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort	262
E. Notice about Medi-Cal estate recovery	263



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *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. Federal notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

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.

C. Notice about nondiscrimination for Medi-Cal

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we don't 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 Care Services, Office for Civil Rights at 916-440-7370. TTY users can call 711 (Telecommunications Relay Service). If you believe that you've been discriminated against and want to file a discrimination grievance, contact:
 - o By phone: 1-833-897-1342 (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.
 - o In writing:
Anthem Full Dual Advantage Aligned (HMO D-SNP)
Medicare Complaints, Appeals & Grievances



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Mailstop: OH0205-A537
 4361 Irwin Simpson Rd.
 Mason, OH 45040

- o Electronically: Visit the plan's website at www.anthem.com/ca/nondiscrimination

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 916-440-7370. If you can't 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 www.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.

D. 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 isn't 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.

Medi-Cal members must utilize all other health coverage (OHC) prior to Medi-Cal when the same service is available under your health coverage since Medi-Cal is the payer of last resort. This means that in most cases, Medi-Cal will be the secondary payer to the Medicare OHC, covering allowable costs not paid by our plan or other OHC up to the Medi-Cal rate.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

E. Notice about Medi-Cal estate recovery

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-For-Service and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment can't exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at www.dhcs.ca.gov/er or call 916-650-0590.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information**, visit www.anthem.com/ca.

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.

Administrative law judge: An Administrative Law Judge (ALJ) is a judge who hears and decides cases involving government agencies. A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't 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 this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: Refers to our emotional, psychological, and social well-being. In simpler terms: It's about how we think, feel, and interact with others. It's an all-inclusive term referring to mental health and substance use disorder services.

Biological Product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological drug that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable Biosimilar").

Brand name drug: A drug that's 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 and are generally not available until the patent on the brand name drug has ended.

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 this *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



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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 this *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.

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 most 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 management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

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 five tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. 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,



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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 (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

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.

Excluded Services: Services that aren't covered by this health plan.

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

Generic drug: A drug approved by the FDA 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 this *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 (HRA): 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 been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

- 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 **don't** owe any cost-sharing. Providers shouldn't bill you anything for these services.

In Home Supportive Services (IHSS): The IHSS Program will help pay enrolled care providers for services provided to you so that you can remain safely in your own home. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. To receive services, an assessment is conducted to determine which types of services may be authorized for each participant based on their needs. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. County social service agencies administer IHSS.

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 experts who aren't 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.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

Individualized Care Plan (ICP or Care Plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you're 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.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan or affiliated health plans for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

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 facility or hospital. LTSS covered by our plan include Community-Based Adult Services (CBAS), also known as adult day health care, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.

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.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Medi-Cal is the Medicaid program for the State of California.

Medi-Cal: This is the name of California's Medicaid program. Medi-Cal is managed 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 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 facility. 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”).



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

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 Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medi-Cal enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid 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 an MA Plan.

Medicare Part D: The Medicare drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. 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 Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to **Chapter 5** of this *Member Handbook* for more information.

Medi-Medi Plan: A Medi-Medi Plan is a type of Medicare Advantage plan. It's for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services.

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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

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 this *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: Are providers who work with our plan. These providers agree to accept our payment as full payment. We arranged for these providers to deliver covered services to you. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services. “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.

Nursing home or facility: A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsperson: 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 ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of this *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

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: Medicare Part A (hospital insurance) and Medicare 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.



If you have questions, please call Anthem Full Dual Advantage Aligned (HMO D-SNP) at 1-833-897-1342 (TTY: 711). Hours are from 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. **For more information,** visit www.anthem.com/ca.

Out-of-network pharmacy: A pharmacy that hasn't 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 isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan.

Chapter 3 of this *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.

Preventive services: Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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 this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): 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 PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.



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Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over 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 aren't 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.

Providers: Are doctors, nurses, and other people who give you services and care and are licensed by the state. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain LTSS.

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 this *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.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) or our 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 this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to **Chapter 4** of this *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 enroll in our plan.



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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 treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, a member will need a referral from their PCP to go to a specialist.

Specialized pharmacy: Refer to **Chapter 5** of this *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 over. SSI benefits aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to get services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency).



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Anthem Full Dual Advantage Aligned (HMO D-SNP) Member Services

CALL	1-833-897-1342 Calls to this number are 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. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are 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.
WRITE	Anthem Blue Cross P.O. Box 60007 Los Angeles CA 90060-0007
WEBSITE	www.anthem.com/ca

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