Health Plan of San Joaquin

Mountain Valley Health Plan

Advantage D-SNP

Member Handbook

2027

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January 1, 2027 – December 31, 2027

Your Health and Drug Coverage under Health Plan of San Joaquin/ Mountain Valley Health Plan Advantage D-SNP (HMO)

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage Dual Special Needs Plan (D-SNP) helps with care and benefits for both Medicare and Medi-Cal. This includes:

- Services covered by Medicare
- Services covered by Medi-Cal.

Services not covered by Medicare Benefits and services are based on eligibility. This Member Handbook describes the benefits and services.

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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.

This document is available for free in English, Spanish, Cambodian, and Vietnamese.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Service at 1-888-361-7526 (TTY 711), Monday to Friday from 8:00 a.m. to 8:00 p.m. This call is free.

Call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP to share your preferred language or format. We will ask if the request is for one document or for all.

If you request English, Spanish, Cambodian, Vietnamese, or other format for all documents, this is called a standing request. Your preference will be kept in our system for all future mailings and communications. You only have to request these options once. Requests for other languages must be made for each document.

To update your preference any time, call 1-888-361-7526 (TTY 711), 8:00 a.m. to 8:00 p.m. seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. The call is free. For more information, visit www.hpsj-mvhp.org

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

English

ATTENTION: If you need help in your language, call **1-888-361-7526 (TTY: 711)**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-888-361-7526 (TTY: 711)**. These services are free of charge.

العربية (Arabic)

يرجى الانتباه :إذا احتجت المساعدة بلغتك، فاتصل بـ **1-888-361-7526**. تتوفر أيضا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والخط الكبير. اتصل بـ**1-888-361-7526 (TTY: 711)**. هذه الخدمات مجانية

Հայերեն (Armenian)

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हिंदी (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है, तो **1-888-361-7526 (TTY: 711)** पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। **1-888-361-7526 (TTY: 711)** पर कॉल करें। ये सेवाएं निःशुल्क हैं।

Hmoob (Hmong)

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日本語 (Japanese)

注意：日本語の対応が必要な場合は、**1-888-361-7526 (TTY: 711)**へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスを用意しています。**1-888-361-7526 (TTY: 711)**へお電話ください。これらのサービスは無料で提供しています。

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ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໃຫ້ໂທຫາເບີ **1-888-361-7526 (TTY: 711)**.
ຍັງມີຄວາມຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນອັກສອນນູນ ແລະ ມີໂຕພິມໃຫຍ່, ໃຫ້ໂທຫາເບີ **1-888-361-7526 (TTY: 711)**.
ການບໍລິການເຫຼົ່ານີ້ແມ່ນບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໆ

Mien

LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux **1-888-361-7526 (TTY: 711)**. Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx **1-888-361-7526 (TTY: 711)**. Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

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ចំណាំ៖ បើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក
សូមទូរសព្ទទៅលេខ **1-888-361-7526 (TTY: 711)**។ ជំនួយ
និងសេវាកម្មសម្រាប់ជនពិការ
ដូចជាឯកសារសរសេរជាអក្សរផុសសម្រាប់ជនពិការ
និងជាពុម្ពអក្សរធំក៏អាចរកបានផងដែរ។ ទូរសព្ទទៅលេខ **1-888-361-7526 (TTY: 711)**។ សេវាកម្មទាំងនេះមិនគិតថ្លៃទេ ។

فارسی (Farsi)

توجه :اگر می‌خواهید به زبان خود کمک دریافت کنید، با **1-888-361-7526** تماس بگیرید .کمک‌ها و خدمات مخصوص افراد دارای **(TTY: 711)** معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است .با تماس بگیرید .این خدمات رایگان ارائه **1-888-361-7526 (TTY: 711)** می‌شوند.

Русский (Russian)

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Español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al **1-888-361-7526 (TTY: 711)**. También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al **1-888-361-7526 (TTY: 711)**. Estos servicios son gratuitos.

Tagalog (Filipino)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-888-361-7526 (TTY: 711)**. Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at

malaking print. Tumawag sa **1-888-361-7526 (TTY: 711)**. Libre ang mga serbisyong ito.

ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1-888-361-7526 (TTY: 711). นอกจากนี้ ยังพร้อมใหค้ วามช่วยเหลือและบริการต่าง ๆ ส าหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วย ตัวอักษรขนาดใหญ่. กรุณาโทรศัพท์ไปที่หมายเลข 1-888-361-7526 (TTY: 711). ไม่มีค่าใช้จ่ายส าหรับบริการเหล่านี้.

Українська (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер **1-888-361-7526 (TTY: 711)**. Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на Номер **1-888-361-7526 (TTY: 711)**. Ці послуги безкоштовні.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số **1-888-361-7526, TTY 711**. Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và bản in khổ chữ lớn. Vui lòng gọi số **1-888-361-7526, TTY 711**. Các dịch vụ này đều miễn phí.

Other languages

You can get this *Member Handbook* and other plan materials in other languages for free. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP provides written translations from qualified translators. Call 1-888-361-7526 (TTY 711). The call is free. Read this *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 1-888-361-7526 (TTY 711). The call is free.

Language Access Services

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 1-888-361-7526 (TTY 711). The call is free.

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Disclaimers

- Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP is an HMO with a Medicare and Medi-Cal contract. Enrollment in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP depends on contract renewal.
- Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP (HMO) complies with all applicable state and federal civil rights laws and does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
- Limitations, copays and restrictions may apply. For more information, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Customer Service or read the Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP pay for your services.
- The List of Covered Drugs and/or pharmacy and provider networks may change throughout the year. We will send you a notice before we make a change that affects you.
- 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.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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*.

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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.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will help you manage your health care by:

- Providing your health care services and prescriptions
- Providing care coordination to help you manage your providers and services. This ensures they all work together to meet your health goals.
- Giving you access to a provider network with primary care physicians (PCPs), dentists, specialists, clinics, pharmacies, and hospitals
- Helping you find behavioral health and long-term services and supports
- Information about Medicare and Medi-Cal

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**
- 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 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:

- 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.
- Your test results are shared with all of your doctors and other providers, as appropriate.

New members to Health Plan of San Joaquin/ Mountain Valley Health Plan Advantage D-SNP: In most instances you'll be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP for your Medicare benefits the 1st day of the month after you request to be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. There will be no gap in your Medi-Cal coverage. Please call us at 1-888-361-7526 (TTY: 711) if you have any questions.

D. Our plan's service area

Our service area includes these counties in California: San Joaquin, Stanislaus, Alpine and El Dorado.

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're eligible for our plan as long as you:

- live in our service area (incarcerated individuals aren't considered living in the service area even if they're 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 5 month(s), we'll continue to provide all Medicare and Medi-Cal covered benefits. During this time, we'll assist

you to regain Medi-Cal eligibility. If you can't regain Medi-Cal within 5 month(s), we'll disenroll you from Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. If you regain Medi-Cal eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Call Customer Service for more information.

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'll reach out to you to complete the HRA. We can complete the HRA by 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.
    - We determine an existing relationship by reviewing your available health information or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. You can make this request by calling 1-888-361-7526 (TTY: 711). If you're at risk of harm, we must respond within three days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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.

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 and social needs that reflects what services you will receive to reach and keep your best physical, mental, and social well-being,
- 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.

H. Summary of Important Costs

Our plan has no premium.

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 Customer Service 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, 2027, and December 31, 2027.

J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, a *Provider and Pharmacy Directory*, 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 your Member ID Card is damaged, lost, or stolen, call Customer Service 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:

- Specialty mental health services that you may get from the County Mental health plan, Behavioral Health Recovery Services.
- Drugs that are not covered through Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP but are instead covered through Medi-Cal Rx such as some over-the counter drugs and certain vitamins. Visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for a list of Medi-Cal network pharmacies. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273. When the Medi-Cal BIC card is used to get drugs not covered by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP, Medi-Cal Rx is responsible for processing the prescription. Visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov) for a list of Medi-Cal Rx network pharmacies.

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 Customer Service 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 doctors, nurses, and health care workers by their specialty. Examples are allergy or radiology. Each listing will show the basic information about the provider or pharmacy:

- Location, hours, and phone number
- If new patients are being accepted
- Which language(s) the staff speaks beside English
- Handicap accessibility
- If the location is near public transportation

Definition of network providers

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

Call Customer Service at the numbers at the bottom of the page for more information. Both Customer Service and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

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 B.** Medicare approved the Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP *Drug List.*

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 Customer Service 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 such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6** 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 Customer Service 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 any information changes, call Customer Service 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, Section C1** of this *Member Handbook*.

Chapter 2: Important phone numbers and resources

Introduction

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

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A. Customer Service

Contact Type	
CALL	1-888-361-7526. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April through September 30. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April through September 30.
FAX	1-209-461-2550
WRITE	7751 South Manthey Road French Camp, CA. 95231
WEBSITE	www.hpsj-mvhp.org

Contact Customer Service to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your health care

- An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
- To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Customer Service.

- 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 1-888-361-7526, TTY 711.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above and Chapter 9.)
  - 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
  - You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
  - If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above appeals about your health care.)
  - 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.
  - For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- payment for health care or drugs you already paid for
  - Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP is not responsible for paying you back for a drug that is only covered under Medi-Cal Rx. If you pay the full cost of a drug that is covered by Medi-Cal Rx or us, the pharmacy may pay you back once Medi-Cal Rx pays for the drug. You may also ask Medi-Cal Rx to pay you back by making a “Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)” claim. Visit the Medi-Cal Rx website to learn more: https://medi-calrx.dhcs.ca.gov/home/.
  - 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*.
  - 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

A care coordinator is a person trained to help you manage the care you need. 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. You get a care coordinator when you enroll in our plan. Call us at 1-800-822-6226 for information about your care coordinator or to request a change of your care coordinator.

CALL	1-800-822-6226. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.
FAX	1-209-461-2550
WRITE	7751 South Manthey Road French Camp CA. 95231
WEBSITE	www.hpsj-mvhp.org

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

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.

Contact Type	
CALL	San Joaquin & El Dorado Counties: 1-800-434-0222 or 1-916-376-8915; Monday – Friday, 9 a.m. – 4 p.m. (Lunch 12 p.m. - 1:30 p.m.) Stanislaus County: 1-209-558-4540; Monday – Friday, 8:30 a.m. to 4:30 p.m. Alpine County: 1-209-532-6272 ext. 226; Monday – Friday, 8 a.m. – 4 p.m.

Contact Type	
TTY	711. This call is free.
WRITE	Alpine County: 19074 Standard Road, Suite A, Sonora, CA 95370 El Dorado and San Joaquin County: 505 12th Street, Sacramento, CA 95814 Stanislaus County: 3500 Coffee Road, Suite 19, Modesto CA 95355
EMAIL	Alpine County: info@area12.org El Dorado & San Joaquin Counties:jtan@lsnc.net Stanislaus County: florescr@stancounty.com
WEBSITE	https://cahealthadvocates.org/hicap/

Contact HICAP for help with:

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

D. Nurse Advice Call Line

You can contact the Nurse Advice Call Line with questions about your health or health care.

Contact Type	
CALL	1-800-655-8294. This call is free. 24 hours/day, 7 days/week We have free interpreter services for languages other than English.
TTY	711. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

E. Behavioral Health Crisis Line

Contact Type	
CALL	Call your county mental health plan. To find all counties' toll-free telephone numbers online, go to: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx **San Joaquin County Behavioral Health Services** 1-888-468-9370 **Stanislaus County Behavioral Health & Recovery Services** 1-888-376-6246 **Alpine County Behavioral Health Services** 1-800-318-8212 **El Dorado County Behavioral Health Services** 1-800-929-1955 If you or someone you know is in crisis, please contact the 988 Suicide and Crisis Lifeline. **Call or text 988** or **chat online at 988lifeline.org/chat**. The 988 Suicide and Crisis Lifeline offers free and private support for anyone in crisis, including help with: ▪ Emotional distress ▪ Suicidal crisis ▪ Mental health crisis ▪ Substance use crises Other phone numbers to assist are the National Suicide Prevention Lifeline 1-800-273-8255 and National Crisis Text Line. Text "Hello" to 741741. This call is free. 24 hours a day, 7 days a week We have free interpreter services for languages other than English.
TTY	711. This call is free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

Contact the Behavioral Health Crisis Line for help with:

- questions about behavioral health and substance abuse services

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 Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health BFCC-QIO is an independent organization. It's not connected with our plan.

Contact Type	
CALL	1-877-588-1123
TTY	711. The call is free.
WRITE	BFCC-QIO Program Commence Health PO Box 2687 Virginia Beach, VA 23450
WEBSITE	Commence Health BFCC-QIO

Contact Commence Health for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care such as getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. Medicare

Medicare is the federal health insurance program for people 65 years of age or 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.

Contact Type	
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

Contact Type	
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.

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.

Contact Type	
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.

Contact Type	
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
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 CalWORKs (California Work Opportunity and Responsibility for Kids), Aging and Community Services, IHSS (In-Home Supportive Services), Food Assistance, Cash Aid Programs, and Medi-Cal Eligibility benefits, benefits, contact your local County Social Services agency. Some social service assistance programs can help cover the cost of essential services, provide support in finding employment, and offer personal care assistance, helping you live safely and independently in the community.

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 safe 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 with any questions about your Medi-Cal eligibility.

Contact Type	
CALL	**Alpine County Health and Human Services**, call 1-530-694-4435. Monday – Friday 8:00 a.m. - 5:00 p.m. **El Dorado County Health and Human Services Agency**, Placerville call 1-530-642-7300 for South Lake Tahoe call 1-530-573-3200. Monday – Friday 8:00 a.m. - 5:00 p.m. 24 Hour. **San Joaquin County Human Services Agency**, call 1-209-468-1000. Monday – Friday 8:00 a.m. - 5:00 p.m. **Stanislaus County Community Service Agency**, call 1-209-558-2500. Monday – Friday 8:00 a.m. - 5:00 p.m. This call is free.
TTY	711. This call is free.

Contact Type	
WRITE	**Alpine County Health and Human Services Agency**, 75 A Diamond Valley Rd., Markleeville, CA 96120 **El Dorado County Health and Human Services Agency**, Placerville 3057 Ridge Court #A, Placerville, CA 95667, South Lake Tahoe 3368 Sandy Way, South Lake Tahoe, CA 96150 **San Joaquin County Human Services Agency**, 333 E. Washington Street, Stockton, CA 95202 **Stanislaus County Community Services Agency**, 251 Hackett Rd. Modesto, CA 95358
WEBSITE	**Alpine County Health and Human Services Agency**, https://alpinecountyca.gov/203/Social-Services **El Dorado County Health and Human Services Agency**, www.eldoradocounty.ca.gov/Health-Well-Being/Human-Services **San Joaquin County**, www.sjchsa.org/ **Stanislaus County Community Services Agency**, www.csa-stanislaus.com/

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.

Contact Type	
CALL	**Alpine County Behavioral Health Services**, call 1-530-694-1816 (local number) or 1-800-318-8212 **El Dorado County Behavioral Health West Slope Office**, call 530-621-6290 (local number) or 1-800-929-1955 **San Joaquin County Substance Abuse Services Administration**, call 1-209-468-9370 (local number) or 1-888-468-9370 **Stanislaus County Behavioral Health & Recovery Services**, call 1-888-376-6246 This call is free. 24 hours a day, 7 days a week. We have free interpreter services for languages other than English.
TTY	711. This call is free.

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.

Contact Type	
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/

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."

Contact Type	
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

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 California 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**, Monday–Friday, 8:00 a.m. – 5:00 p.m. (excluding holidays).**

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.
WEBSITE	www.ssa.gov

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

- 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

CALL	1-800-322-6384 The call is free. Medi-Cal Dental FFS 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

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.

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*.

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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. 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 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 women'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. 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:
  - If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section H**).
  - 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. Out-of-network care will require authorization, and your PCP should submit an authorization request for necessary service. In this situation, we cover the care as if you got it from a network provider **or** at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4**.
  - 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.
  - 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP: In most instances, you'll be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP for your Medicare benefits the 1st day of the month after you request to be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Care Coordinator helps you manage and navigate your health care so that you can reach your health care goals. Your Care Coordinator is knowledgeable about your benefits and works to help you get those benefits. Contact Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP care management to learn more.

C1. What a care coordinator is

A care coordinator is a trained person who works for our plan to provide care coordination services for you.

C2. How you can contact your care coordinator

- You can call 1-800-822-6226. The hours are Monday through Friday, 8:00 a.m. to 5:00 p.m. The call is free.
- TTY users can call 711. The call is free

We have interpreter services for languages other than English.

C3. How you can change your care coordinator

- You can call 1-888-361-7526 to request to change your Care Manager.

D. Care from providers

D1. Care from a primary care provider (PCP)

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

Definition of a PCP and what a PCP does for you

What a PCP is

Your PCP is the licensed provider you go to for most of your health care. Your PCP also helps you get other types of care you need. Depending on your age and sex, you can choose a general practitioner, OB/GYN, family practitioner, internist, or pediatrician as your PCP.

The role of a PCP in

- coordinating covered services
- making decisions about or getting prior authorization (PA), if applicable

When a clinic can be your PCP:

- A Rural Health Center or Federally Qualified Health Center (RHC/FQHC) can be your PCP.

Your choice of PCP

- Your PCP may have particular specialists or hospitals they want to use, but you can see any specialist or use any hospital in the network.

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.

You can change your PCP at any time by calling Customer Service at the phone number 1-888-361-7526.

If you need help choosing a PCP, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Customer Service. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). We will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. We will also check to be sure the PCP you want to switch is accepting new patients. Customer Service will change your member record to show the name of your new PCP and tell you when the change to your new PCP will take effect.

Services you can get without approval from your PCP

In most cases, you need a referral from your PCP and/or an authorization from our plan. You can get services like the ones listed below without getting a referral or an authorization 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.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. If you call Customer Service before you leave the service area, we can help you receive dialysis while you're away.
- Flu shots and COVID-19 vaccine as well as hepatitis B vaccines and pneumonia vaccines.
- 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.

Your PCP may refer you specialists and other providers. If you need services that require Prior Authorization (PA), Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will review the PA based on medical necessity.

Certain services require PA, which means your doctor will send a request to your plan for review and a decision based on rules for reviewing requests. Refer to Chapter 4 Section D for information about which services require PA.

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.
- 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 authorize and 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. We must authorize services out of network, when an in-network provider is unavailable.
- 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

Sometimes special types of providers are not in network. If no network provider can offer that service, the request will then be sent to an out of network provider.

- 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.

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.

Usually, to qualify for LTSS you must be 18 years old or older. You must also be enrolled in a Medi-Cal Managed Care Plan like the Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. You may also qualify if you need physical support, or support with function or behavior. These needs can require long-term support to remain safely at home. Sometimes you can get help with your daily health care and living needs. Members must meet certain requirements to qualify for each of these programs. Call your Care Coordinator at 1-888-361-7526 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. The call is free.

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 your local county Behavioral Health Department. Call your county mental health plan. To find all counties' toll-free telephone numbers online, go to:
http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx:
http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx or call:

- Alpine County Behavioral Health Services, call 1-530-694-1816 (local number) or 1-800-318-8212
- El Dorado County Behavioral Health West Slope Office, call 1-530-621-6290 (local number) or 1-800-929-1955

- San Joaquin County Substance Abuse Services Administration, call 1-209-468-9370 (local number) or 1-888-468-9370
- Stanislaus County Behavioral Health & Recovery Services, call 1-888-376-6246

You can also refer to **Chapter 2**, **Section K.**

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 your county behavioral health agency, such as Alpine County Behavioral Health, El Dorado County Behavioral Health, San Joaquin County Behavioral Health and Stanislaus County Behavioral Health and Recovery Services 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
- 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
- peer support services
- community-based mobile crisis intervention services
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services

Drug Medi-Cal (DMC) services provided by Alpine County 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)
- peer support services
- community-based mobile crisis intervention services

Drug Medi-Cal Organized Delivery System (DMC-ODS) services are available to you through El Dorado, San Joaquin, and Stanislaus counties if you meet criteria to receive these services. DMC-ODS Services include:

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

- narcotic treatment program
- recovery services
- care coordination
- peer support services
- community-based mobile crisis intervention services (Not applicable to Alpine)
- contingency management services early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)
- inpatient treatment services

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

Voluntary Inpatient Detoxification (VID) services are a Medi-Cal covered benefit that is available to MCP members through the Medi-Cal fee-for-service (FFS) program. Members who meet medical necessity criteria may receive VID services in a general acute care hospital.

VID services are covered through the Medi-Cal FFS program. Inpatient detoxification must be the main reason for the member's voluntary stay. Sometimes a doctor can decide whether a member does not meet these requirements. If this happens, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will refer the member to County Behavioral Health Services. County Behavioral Health Services can then refer to other substance use disorder (SUD) treatment services. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will help with this process.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will refer members to general acute care hospitals for VID services. The VID facility cannot be a Chemical Dependency Treatment Facility or an Institution for Mental Disease. The VID provider must submit a Treatment Authorization Request (TAR) to local Medi-Cal field offices for authorization. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will help arrange service with the VID provider as needed. Paperwork submitted with the TAR should show that the above requirements are met. Paperwork should also explain the medical need for the inpatient stay.

State law requires that medically necessary services must not be delayed while County Behavioral Health Services and Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP resolve any disputes. State law also decides who has to pay for services

provided to a member during that time. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP has to provide case management and care coordination for all medically necessary services. This includes services that are the subject of a dispute between County Behavioral Health Services and Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP has to work with County Behavioral Health Services to ensure there is no repeat SMHS, for which County Behavioral Health Services also provides case management.

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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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:

- 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 physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent routine appointments, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP

at 1-888-361-7526 (TTY:711) at least seven (7) to ten (10) business days (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

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will help you schedule your transportation. A list of covered services is in **Chapter 4** of this handbook. Transportation isn't covered outside Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP 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.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage uses a 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. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 or emailing, or in person. **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.

To ask for a ride for services that have been authorized, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at 1-888-361-7526 (TTY:711) at least seven (7) to ten (10) business days (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

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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:
  - There isn't enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use 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 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. Call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at 1-888-361-7526 (TTY 711), 8:00 a.m. to 8:00 p.m. seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories.

Medicare covers medical services and drugs that you get in the United States and its territories (for example, Puerto Rico, Guam, etc.). Medicare does not cover medical services or drugs that you get outside the United States except in limited situations. Medi-Cal may also cover emergency care that requires hospitalization in Canada or Mexico.

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.

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.

If you don't know if the injury or illness is urgent, call your Primary Care Provider (PCP).

You should always go to the PCP for care. If you can't reach your PCP after hours, call the 24-hour Nurse Advice Line at 1-800-655-8294 to get help when you need it.

If needed, our Nurse can connect you to speak with a doctor by phone or video chat. If our nurse thinks you need more help, they will point you to an open Urgent Care Clinic nearby. Urgent care clinics are open after hours and weekends, and some provide lab work and x-rays.

Urgently needed care outside our plan's service area

When you're traveling 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.

Medicare does not cover medical services or drugs that you get outside the United States except in limited situations. Medi-Cal may also cover urgent/emergent care that requires hospitalization in Canada or Mexico. Our plan doesn't cover urgently needed care or any other care that you get outside the United States and its territories.

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.hpsj-mvhp.org.

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.

I1. 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 Customer Service to learn more about your appeal rights.

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 Customer Service 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 Customer Service 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.

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 (refer to 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, 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.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP covers the purchase or rental of DME supplies, equipment, and other services under Medi-Cal. A prescription from a Provider is needed. That can be a doctor, physician assistant, nurse practitioner, or clinical nurse specialist. DME items are covered as medically necessary to support daily living or to prevent major disability.

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP does not cover:

- Comfort, convenience, or luxury equipment. This includes features, and supplies. Except retail-grade breast pumps. See "Breast pumps and supplies" in "Maternity and newborn care."
- Items not used for normal activities of daily living. Example: exercise equipment, items used to support recreation or sports.
- Hygiene equipment. Except when medically necessary for a member under age 21.
- Nonmedical items. Example: sauna baths or elevators.

- Changes to homes or cars
- Devices for testing blood or other body substances. Example: diabetes blood glucose monitors, continuous glucose monitors, test strips, and lancets. These are covered by Medi-Cal Rx.
- Electronic monitors of the heart or lungs. Except infant apnea monitors.
- Repair or replacement of equipment due to loss, theft, or misuse. Except when medically necessary for a member under age 21.
- Other items not used for health care.
- In most cases, these items must be approved. Your doctor must submit a request for pre-approval.

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.

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
- 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.

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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP: In most instances you'll be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP for your Medicare benefits the 1st day of the month after you request to be enrolled in Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. There will be no gap in your Medi-Cal coverage. Please call us at 1-888-361-7526 and TTY 711 if you have any questions.

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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*.

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 your care coordinator at 1-800-822-6226 and/or Customer Service at 1-888-361-7526.

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 Customer Service.

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.
- 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.
- 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 an asterisk (*) or 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 CY 2027, either Medicare or our plan will cover those services.
- If you're within our plan's 5-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage and Medi-Cal plan-covered benefits. During this time, we'll assist you to regain Medi-Cal eligibility. 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.

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
	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. **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Acupuncture (continued) 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:** 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.	

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.	$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.	$0

	Covered Service	What you pay
🍎	**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. ***Prior authorization required after first covered service if medically necesssary.**	$0

Covered Service		What you pay
	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 • clinical breast exams once every 24 months *Based on calendar year*	$0

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 prior authorization. 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. * Prior authorization required	$0

Covered Service		What you pay
	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
	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

Covered Service		What you pay
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment	$0

Covered Service		What you pay
	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. • 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 **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Colorectal cancer screening (continued) • 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.	$0

	Covered Service	What you pay
	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. Certain dental services are available through the Medi-Cal Dental Program or FFS Medi-Cal. If you have questions or want to learn more about dental services, call the Medi-Cal Dental Program at 1-800-322-6384 (TTY 1-800-735-2922 or 711). You may also visit the Medi-Cal Dental Program website at: https://smilecalifornia.org/contact-us/.http://www.hpsm.org/dental	$0
	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. *Based on calendar year*	$0
	Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Diabetes screening (continued) • 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.	$0

	Covered Service	What you pay
	Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ○ a blood glucose monitor ○ blood glucose test strips ○ lancet devices and lancets ○ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: ○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customer Service.	$0
	Doula services For individuals who are pregnant, we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery. Up to nine additional postpartums may be provided as well.	$0

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of this *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs, including electric wheelchairs • crutches • powered mattress systems • dry pressure pad for mattress • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) **This benefit is continued on the next page**	$0

Covered Service		What you pay
	Durable medical equipment (DME) and related supplies (continued) • 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. If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor can file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is appropriate for your medical condition. For more information about appeals, refer to **Chapter 9** of this *Member Handbook.* *Prior authorization is required.	$0

Covered Service		What you pay

	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:
	  ○ There isn't enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	The plan only covers emergency care within the U.S. and its territories
		$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.

Covered Service		What you pay
	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: • 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	

Covered Service		What you pay
	Health and wellness education programs We offer many programs that focus on certain health conditions. These include: • health education classes; • nutrition education classes; • smoking and tobacco use cessation; **and** • nursing hotline Programs may be offered in person, over the phone, or through mail.	$0

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.
	• Supplemental Hearing Benefit:
	  ○ One routine hearing exam per year
	  ○ One fitting/evaluation for hearing aid per year
	  ○ Our plan pays up to $1200 above the state Medi-Cal limit for hearing aids, molds, modifications and accessories.
	  ○ Total benefit applies to both ears combined.
	
	*Prior authorization is required for fitting/evaluation and hearing aid.
		$0

	Covered Service	What you pay
	HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. 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
	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 eight hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies * Prior authorization is required	$0

Covered Service		What you pay
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but 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; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. *Prior authorization is required.	$0

Covered Service		What you pay
	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 When you're admitted to a hospice, you have the right to stay in our plan. **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 they relate to your terminal prognosis. You pay nothing for these services. **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Hospice care (continued) **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 *Member Handbook*. **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 Customer Service to arrange the services. Non-hospice care is care that **isn't** related to your terminal prognosis.	$0

Covered Service		What you pay
	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 • 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 *Member Handbook* to learn more.	$0

Covered Service		What you pay
	Inpatient hospital care We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • 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. *Prior authorization is required **(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.

Covered Service		What you pay
	Inpatient hospital care (continued) 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 local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. • blood, including storage and administration. • physician services **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 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 *Medicare Hospital Benefits* 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. *Except in an emergency, prior authorization is required	

Covered Service		What you pay
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency. ○ The 190-day limit **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). *Prior authorization is required	$0

Covered Service		What you pay

	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 Customer Service.
	
	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:
	  ○ an internal body organ (including contiguous tissue), **or**
	  ○ the function of an inoperative or malfunctioning internal body organ.
	• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition
	• physical therapy, speech therapy, and occupational therapy
		$0

Covered Service		What you pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of this *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to "Medicare Part B drugs" in this chart.	$0

Covered Service		What you pay
	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

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 ***or*** 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 order 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

Covered Service		What you pay
	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) • 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 *Prior authorization is required **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Medicare Part B drugs (continued) • 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 • 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 ***Prior authorization is required** **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Medicare Part B drugs (continued) • 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 • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: www.hpsj-mvhp.org. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D drug benefit. *Prior authorization is required **Chapter 5** of this *Member Handbook* explains our drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of this *Member Handbook* explains what you pay for your drugs through our plan.	$0

Covered Service		What you pay
	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 **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Nursing facility care (continued) • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • 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. *Prior authorization is required	$0

	Covered Service	What you pay
	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 • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	$0

Covered Service		What you pay
	Over-the-Counter (OTC) Items We cover some Over-the-Counter (OTC) products through our supplemental benefit OTC program at no cost to you. You will receive an allowance or spending limit of $145 per quarter (every 3 months), to purchase OTC items and supplies at retail stores, through the OTC mail-order catalog, or our vendor's website. This benefit becomes available on the first day of each quarter: January 1, April 1, July 1 and October 1. Any unused card allowance will not carry over to the next quarter. You can use this benefit to get items such as pain relief, first aid, cold and cough medicines and other eligible products as offered by our OTC vendor. Items must be part of CMS authorized list of approved OTC products.	$0

Covered Service		What you pay
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • 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 *Prior authorization may be required for some tests and lab services.	*$0

Covered Service		What you pay
	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. **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 *Medicare Hospital Benefits* available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf	$0

Covered Service		What you pay
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • 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 *Prior authorization is required	$0

Covered Service		What you pay
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (CSW) • a clinical nurse specialist (CNS) • 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 **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Outpatient mental health care (continued) • 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	$0
	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. *Prior authorization is required for occupational and speech therapy services.	$0

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	$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. *Prior authorization is required	$0

Covered Service		What you pay
	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. 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.	$0

Covered Service		What you pay
	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. *Prior authorization is required	$0

Covered Service		What you pay
	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, if your doctor orders them to find out whether you need treatment **(This benefit is continued on the next page)**	$0

Covered Service		What you pay
	Physician/provider services, including doctor's office visits (continued) • 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.	$0

Covered Service		What you pay

	Physician/provider services, including doctor's office visits (continued)
	• 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**
	  ○ 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 before surgery
		$0

	Covered Service	What you pay
	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 *Prior authorization is required	$0
	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 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 eight HIV screenings every 12 months. • A one-time hepatitis B virus screening.	$0
	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

Covered Service		What you pay
	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 • 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. *Prior authorization is required	$0

Covered Service		What you pay
	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. *Prior authorization is required	$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, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	$0

Covered Service		What you pay
	Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0

	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: • 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 • 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 **(Continued from previous page)**	$0

Covered Service		What you pay
	*Prior authorization is required	
🍎	**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 providers counseling 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).	$0

Covered Service		What you pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse specialist (CNS) trained in both basic and advanced life support techniques *No prior authorization for the initial visit. Prior authorization required for additional visits.	$0

Covered Service		What you pay
	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 • To ask for medical transportation that your doctor has prescribed for non-urgent (routine) appointments, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at 1-888-361-7526, (TTY 711) at least seven (7) to ten (10) business days (Monday - Friday) before your appointment. For urgent appointments, call as soon as possible.	$0

Covered Service		What you pay
	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 appointments and to pick up drugs. Transportation for services dually covered by Medi-Cal and Medicare are covered. To request a ride for services that have been authorized, call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP at 1-888-361-7526 (TTY 711) at least seven (7) to ten (10) business days (Monday - Friday) before your appointment, or as soon as you can when you have an urgent appointment.	$0

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). Urgent care is covered in and out-of-network without prior authorization. Not covered outside of the U.S. except in limited situations.	$0

	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. Supplemental Vision Benefit: • Routine eye exam (up to 1 every year) • One pair of eyeglass lenses every two years (covered base lenses includes single vision, lined bifocal, lined trifocal or lenticular) • One pair of eyeglass frames every two years up to $300 allowance.	$0

Covered Service		What you pay
	• You may receive one pair of contact lenses in lieu of eyeglass lenses and frames every two years up to a $115 allowance.	
	"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** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

E. 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.

Community Supports that we offer are listed below. All community supports requests require prior authorization except Sobering Centers. Community Supports are optional services offered at the discretion of our plan. These services may change, be added, or end from time to time. For the most accurate and up-to-date list of available Community Supports, please visit our website at www.hpsj-mvhp.org or call Customer Service at 1-888-361-7526 (TTY 711).

- **Housing Transition Navigation Services:** To assist members with finding, applying for, and obtaining housing. Eligible members experiencing homelessness must meet DHCS Community Supports criteria and services can be provided if appropriate and

authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.

- **Housing Deposits:** To assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household. Eligible members who are homeless or at risk of homeless must meet DHCS Community Supports criteria and can be provided if appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available once in a lifetime**.**

- **Housing Tenancy and Sustaining Services:** Services to help a member maintain safe and stable tenancy once housing is secured. Eligible homeless, or at risk of homeless members must meet DHCS Community Supports criteria and can be provided if appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available for a single duration in the individual's lifetime and will only be approved one additional time if medically appropriate.

- **Recuperative Care:** Also referred to as medical respite care, is for individuals who are experiencing or at risk of homelessness and need a short-term residential setting in which to recover from an injury or illness (including a behavioral health condition) and who meet DHCS Community Supports criteria. Further, this service must be determined to be appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.

- **Meals/Medically Tailored Meals:** This service helps to address individuals' chronic or other serious conditions that are nutrition sensitive, leading to improved health outcomes. Eligible members must meet DHCS Community Supports, and service must be determined to be appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Available for up to two meals per and or medically supportive food and nutrition services up to 12 weeks or longer if medically necessary. Meals must not be eligible to be reimbursed by other programs and not covered to respond solely to food insecurities.

- **Sobering Center:** Provides alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are experiencing homelessness or those with unstable living situations, with a safe, supportive environment to become sober. Service is covered for a duration of less than 24 hours. Sobering centers do not require prior authorization, and members may go directly to sobering center providers to receive services.

- **Asthma Remediation:** Consists of supplies and/or physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of a member, or to enable a member to function in the home with reduced likelihood of experiencing acute asthma episodes. Service must meet DHCS Community Supports criteria and be determined to be appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available up to a lifetime maximum unless additional needs are supported by member's condition.

- **Environmental Accessibility Adaptations (Home Modifications):** also known as Home Modifications, are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the member would require institutionalization and meet DHCS Community Supports criteria. Services must be determined to be appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available up to a lifetime maximum unless additional needs are supported by member's condition.

- **Day Habilitation Programs:** Programs designed to assist the member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The service is provided in a member's home or in an out-of-home, non-facility setting. Eligible members include those who are homeless or at risk for homelessness and meet DHCS Community Supports criteria. Services must be determined to be appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available to members as medically appropriate.

- **Personal Care and Homemaker Services:** Services provided to individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management. Eligible members may include members at risk for care in a nursing facility, members with disabilities, members who lack social support and IHSS members. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. This service is available as medically appropriate.

- **Respite Services:** Short-term services provided to caregivers of members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care

for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Eligible members may include members who live in the community and are compromised in their Activities of Daily Living and depend on their caregivers to provide most of their support and require caregiver relief to avoid institutional placement. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. The service limit is up to 336 hours per calendar year. This service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made with Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP authorization if caregiver experiences an episode including medical treatment and hospitalization.

- **Assisted Living Facility Transition:** Services to help members live in the community and avoid institutionalization, when possible. Eligible members are those who have resided in a nursing facility for 60+ days and are willing and able to transition and divert to an assisted living facility. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Members may receive services as medically appropriate. Members are directly responsible for paying for their own living expenses.

- **Community or Home Transition Services:** Services to help members live in the community and avoid further institutionalization by providing non-recurring set up expenses for individuals transitioning from a licensed facility to a living arrangement in a private residence. Eligible members are those currently receiving medically necessary facility level of care, have lived 60+ days and are interested and able to reside safely back in the community. Services must meet DHCS Community Supports criteria and be determined appropriate and authorized by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Community transition services are payable up to a total lifetime maximum amount. The only exception to the total maximum is if the member is compelled to move from a provider operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control. Members may receive services as medically appropriate.

- **Transitional Rent**: Provides up to six months of rental assistance in interim and permanent settings to members who are experiencing or at risk of homelessness, have certain clinical risk factors, and have either recently undergone a critical life transition (such as exiting an institutional or carceral setting or foster care), or who meet other specified eligibility criteria.

If you need help or would like to find out which Community Supports may be available for you, call 1-888-361-7526 or 711 or 711) or call your health care provider.

F. Benefits covered outside of our plan

We don't cover the following services, but they're 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've 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 **doesn't** cover drugs. You continue to get your normal drug benefit through our plan. For more information, refer to **Chapter 5** of this *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.

F2. Medi-Cal Dental

Certain dental services are available through Medi-Cal Dental.

More information is on the SmileCalifornia.org website. Medi-Cal Dental includes, but isn't limited to, services such as:

- initial examinations, X-rays, cleanings, sealants, 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 customer service 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 a.m. to 5 p.m., Monday through Friday. You can also visit the website at smilecalifornia.org/ 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. You can also call San Joaquin Human Services Agency at 1-209-468-1104, Stanislaus County Community Services Agency at 1-209-558-2637, Alpine Health and Human Services 1-530-694-2235, and El Dorado Health and Human Services 1-530-642-4800.

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. You can also visit https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-CCAs.aspx for more information on ALW.

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.
- 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. You can also call Home Health Care Management if you live in San Joaquin or El Dorado County at 1-800-400-0727 or visit https://homeandhealthcaremanagement.com/. If you live in Alpine or Stanislaus County please contact Libertana Home Health at 1-800-750-1444 or visit https://libertana.com.

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.You can also call Rx Staffing and Home Care, Inc at 916-485-8200 if you live in San Joaquin County. If you live in El Dorado County you can contact Sierra Foothills AIDS Foundation at 530-889-2437. For Alpine and Stanislaus County or for additional information you can also visit https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_MCWP_Provider_List.aspx.

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:
    - care management
    - adult day care
    - minor home repair/maintenance
    - supplemental in-home chore, personal care, and protective supervision services
    - respite services
    - transportation services
    - counseling and therapeutic services
    - meal services
    - 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. You can also call Catholic Charities at 209-444-5931 or visit https://www.ccstockton.org if you live in San Joaquin County. If you live in Stanislaus County you can call 209-558-8698 or

visit https://www.stancounty.com/aging/mssp.shtm. If you live in Alpine or El Dorado County you can call the California Health Collaborative at 1-888-752-6777 or visit https://healthcollaborative.org/program/multipurpose-senior-services-program-mssp/contact-us/.

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 doesn't 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
  - 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
- targeted case management
- peer support services
- community-based mobile crisis intervention services
- therapeutic behavioral services

- therapeutic foster care
- intensive care coordination
- intensive home-based services
- 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

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)
- peer support services
- community-based mobile crisis intervention services
- early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)

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

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)

- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- peer support services
- community-based mobile crisis intervention services
- contingency management services
- early intervention services (for members under age 21)
- early periodic screening, diagnosis, and treatment (for members under age 21)
- inpatient treatment services

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

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
- meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it'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
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- 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.

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 F3** "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. 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 (www.medi-calrx.dhcs.ca.gov) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.

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 or any similar Medi-Cal 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, Section G** 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 prescriber may be able to help identify medical references to support the requested use of the prescribed drug.

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

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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 Customer Service

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 Customer Service 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 Customer Service.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Customer Service.

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 Customer Service.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy isn't in our network or you have difficulty getting your drugs in a long-term care facility, contact Customer Service.
- 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 Customer Service.

A6. Using mail-order services to get your drugs

Our plan's mail-order service allows you to order at least a 90-day supply (Tiers 2 ,3, and 4) or 100-day supply (Tiers 1 and 6) depending on the tier placement on the Drug list. A 90-day or 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, refer to the Provider and Pharmacy Directory, visit our website, or contact Customer Service.

Usually, a mail-order prescription arrives within 7 days. If the mail-order prescription is delayed, contact Customer Service at 1-888-361-7526 (TTY:711).

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.

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

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

   - This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allows you to stop or delay the order before you're billed and 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.

3. **Refills on mail-order prescriptions**

   For refills, contact your pharmacy 7 days before your current prescription will run out to make sure your next order is shipped to you in time.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Call Customer Service at 1-888-361-7526 (TTY: 711). The call is free.

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-day 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 Customer Service for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with Customer Service 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:

- When filling a specialized drug that is otherwise not available at a network pharmacy. When filling a drug that has limited distribution
- When filling a drug in an emergency situation when network pharmacies are not available such as emergency illness while traveling or during a declared disaster

A9. Paying you back for a prescription

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. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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 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.*

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

B2. How to find a drug on our *Drug List*

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

- Check the most recent *Drug List* we sent you in the mail.
- Visit our plan's website at www.hpsj-mvhp.org. The *Drug List* on our website is always the most current one.
- Call Customer Service 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.hpsj-mvhp.org 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 Customer Service.

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 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 six 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- This is a preferred generic drug. You can request up to a 100-day supply of this drug at a time through retail or mail order.
- Tier 2- Generic- This is a generic drug. You can request up to a 90-day supply of this drug.
- Tier 3- Preferred Brand- This is a preferred brand name drug. You can request up to a 90-day supply of this drug at a time through retail or mail order.
- Tier 4- Non-Preferred Brand- This is a non-preferred brand drug. You can request up to a 90-day supply of this drug at retail or mail order.
- Tier 5- Specialty- This is a specialty drug. Drugs in this tier are limited to a 30-day supply at a time and can only be obtained through a specialty pharmacy.
- Tier 6- Select Care Drugs- You can request up to a 100-day supply of this drug at a time through retail or mail order.

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.

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. 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 Customer Service at the number at the bottom of the page or on our website at www.hpsj-mvhp.org for more information about prior authorization.

2. 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 Customer Service at the number at the bottom of the page or on our website at www.hpsj-mvhp.org for more information about step therapy.

3. Quantity limits

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 Customer Service or check our website at www.hpsj-mvhp.org. 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.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.

  - Long-term care pharmacies may provide your drug in small amounts at a time to prevent waste.

- You're new to our plan.
  - We cover a temporary supply of your drug **during the first 90** days **of your membership in our plan.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your 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.
  - We cover one 31-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 Customer Service.

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 Customer Service 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.

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 Customer Service.

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're taking?

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

- Check our current *Drug List* online at www.hpsj-mvhp.org **or**
- Call Customer Service 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. If you receive a notice, it will give you directions on the next steps to take.

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 Lis*t 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

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're 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 Customer Service.

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 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.
- 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 Customer Service.

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 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.

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*.
  - We call this the “*Drug List*.” It tells you:

» which drugs we pay for

» if there are any limits on the drugs

  - If you need a copy of our *Drug List*, call Customer Service. You can also find the most current copy of our *Drug List* on our website at www.hpsj-mvhp.org.
  - Most of the drugs you get from a pharmacy are covered by Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx

website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.

- **Chapter 5** of this *Member Handbook*.
  - Explains how to get your outpatient drugs through our plan.
  - It includes rules you need to follow. It also tells which types of drugs our plan doesn't cover.
  - 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 Customer Service for more information.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of this *Member Handbook* for more information about network pharmacies.

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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 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 got 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 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*.

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. You can call Customer Service for instructions to submit receipts. 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, payments made by a State Pharmaceutical Assistance Program 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 Health Plan of San Joaquin/Mountain Valley Health Plan Customer Service at 1-888-361-7526 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Customer Service.
- 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 Customer Service at 1-888-361-7526 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. 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.

C1. Our plan has six drug tiers

- Tier 1 Preferred generic drugs have $0 copay.

- Tier 2 Generic drugs have $0 copay
- Tier 3 Preferred Brand drugs have $0 copay
- Tier 4 Non-Preferred Brand drugs have $0 copay
- Tier 5 Specialty generic drugs have $0 copay
- Tier 5 Specialty brand drugs have $0 copay
- Tier 6 Select Care drugs have $0 copay.

C2. 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 this *Member Handbook* to learn about how to file an appeal if you're told a drug won't be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of this *Member Handbook* and our *Provider and Pharmacy Directory*.

C3. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90 or 100-day supply. There's no cost to you for a long-term supply.

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

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

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 1 (Preferred Generic)	$0	$0	$0	$0
Cost-sharing Tier 2 (Generic)	$0	$0	$0	$0
Cost-sharing Tier 3 (Preferred Brand)	$0	$0	$0	$0
Cost-sharing Tier 4 (Non-Preferred Brand)	$0	$0	$0	$0

	A network pharmacy A one-month or up to a 100-day supply	**Our plan's mail-order service** A one-month or up to a 100-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of this *Member Handbook* for details.
Cost-sharing Tier 5 (Specialty)	$0	$0	$0	$0
Cost-sharing Tier 6 (Select Care Drugs)	$0	$0	$0	$0

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

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 Customer Service for coverage and cost-sharing details 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 Customer Service if you plan to get a vaccine.

- We can tell you about how our plan covers your vaccine.

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*.

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A. Asking us to pay for your 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 **Chapter 7 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.
  - You received the covered service after you became an eligible Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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.
- Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP will pay you back, but only up to the amount that FFS Medi-Cal would pay. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Customer Service if you have any questions. If you don't know what you should've paid, or 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

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 Customer Service** 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.

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 or call us. 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 must send your information to us within 1095 days 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.hpsj-mvhp.org. You can call Customer Service and ask for the form.

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

MedImpact Healthcare Systems, Inc.
PO Box 509108
San Diego, CA. 92150-9108

Fax: 1-858-549-1569
Email: Claims@Medimpact.com

You may also call us to ask for payment. Call Customer Service **1-888-361-7526 (TTY: 711),** 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. The call is free.

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 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 What to do if you have a problem or complaint (coverage decisions, appeals, complaints).**

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 Section G** of this *Member Handboo*k.

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

Chapter 8: Your rights and responsibilities

Introduction

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

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

We must ensure **all** services, 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 your care coordinator or Customer Service. 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 Spanish, Cambodian, and Vietnamese, and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Customer Service or write to Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP, 7751 South Manthey Road, French Camp, CA 95231.
    - Call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP to share your preferred language or format. We will ask if the request is for one document or for all.
    - If you request English, Spanish, Cambodian, Vietnamese, or other format for all documents, this is called a standing request. Your preference will be kept in our system for all future mailings and communications. You only have to request these options once. Requests for other languages must be made for each document.
    - To update your preference any time, Call 1-888-361-7526 (TTY 711), 8:00 a.m. to 8:00 p.m. seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. The call is free. **For more information**, visit www.hpsj-mvhp.org.

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). 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.

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 your care coordinator or Customer Service 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 this *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.

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. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP won't disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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.

- **Request confidential communications**
- You can ask us to contact you by your preferred method of contact (for example, home or work phone) or to send mail to a different address. You can make this request by submitting a Request for Confidential Communication form to Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP. You can request a copy of the form by calling Customer Service or by accessing the form on our website at www.hpsj-mvhp.org.
- We will consider all fair requests. We must say "yes" if you tell us you would be in danger if we do not.
- We protect your personal health information (PHI) as required by federal and state laws.

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's 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.

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. We may charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we 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 Customer Service.

Notice of Privacy Practices

This notice describes how your medical and personal information may be used and disclosed. This includes information about your race/ethnicity, language, gender identity and sexual orientation. This notice also tells you how you can get access to this information. **Please read it carefully.**

Your Rights

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

Get a copy of your health and claims records	You can ask to see or get a copy of your records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records. Usually within 30 days of your request. We may charge a cost-based fee.
Ask us to correct health and claims records	You can ask us to correct your health and claims records if you think they are not correct or not complete. Ask us how to do this. We may say “no” to your request, but we will tell you why in writing within 60 days
Request confidential communications	You can ask us to contact you in a specific way (Example: home/office phone) or mail to a different address. We will consider all reasonable requests. We will say “yes” if you tell us you would be in danger if we do not. We will process all confidential communication changes requested by you. This will happen within 7 calendar days of getting your written request. Within 14 calendar days of getting your request through first class mail. We will send you a letter letting you know we got your request. If you are a senior person with disability (SPD) and have a physical or mental incapacity, you do not need to complete an authorization form.
Ask us to limit what we share about you	You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it will affect your care.
Get a list of those with whom we’ve shared information	You can ask for a list (accounting) of the times we've shared your health information. This will include times six years prior to the date you ask, who we shared it with, and why. We will include all disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free. We will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	You can ask for a paper copy of this notice at any time. Even if you have agreed to get the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you	If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	You can complain if you feel we have violated your rights. Contact us using the information on the back page. You can file a complaint with U.S. Department of Health and Human Services Office D.C. 20201, calling 1-877-696-6755, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints We will not retaliate against you for filing a complaint.
Request Your Health Information Be Sent to an Application of Your Choice	Interoperability Rules require us to provide up to five years of certain health care data when you request it directly with us or through a third-party application. When you request it through a third-party application, Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP reserves the right to approve the third-party application based on security analysis. You can make this request directly with us by accessing the Request to Access Health Information form online (www.hpsj-mvhp.org), requesting it over the phone with a Customer Service Representative, or on a walk-in basis. You can make this request directly with us by accessing the Request to Access Health Information form online (www.hpsj-mvhp.org), requesting it over the phone with a Customer Service Representative, or on a walk-in basis. You must complete the entire form and mail or bring it to the Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP's office located in 7751 South Manthey Road, French Camp, CA 95231. You may also fax the form to: 1-209-461-2550 or send to Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP through a secured email. We are not responsible for the third-party application that you select. We are not responsible for your data once transferred to the third-party application.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a preference for how we share your information in the situations below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

In these cases, we never share your information unless you give us written permission for the following:

- Marketing purposes
- Sale of your information

Also, we will not use your information in the following ways:

- Use race/ethnicity, language, gender identity or sexual orientation to make decisions for underwriting, denial of coverage or require you to give up your rights to enroll in or be covered under Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP.
- Release your medical or personal information about abortion services if the request comes from another state, even if it is a subpoena. You are protected by the California Reproductive Privacy Act.
- Release medical or personal information for children who receive gender-affirming health or mental health care in response to any civil, foreign subpoena, or out of state action.
- Disclose information about substance use disorder (SUD) treatment to a civil, criminal, administrative, or legislative proceedings against a member, without the members' consent or a court order.

- Share your information on services related to sexual and reproductive health, sexually transmitted infections and diseases, and intimate partner violence without your expressive written authorization, except for treatment, payment and operations.

Our Uses and Disclosure

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	We can use your health information and share it with professionals who are treating you.	*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	We can use and disclose your information to run our organization and contact you when necessary. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.	*Example: We use health information about you to develop better services for you.*
Pay for your health services	We can use and disclose your health information as we pay for your health services.	*Example: We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your plan	We may disclose your health information to your health plan sponsor for plan administration.	*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways. Usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues	We can share health information about you for certain situations such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety
Do research	We can use or share your information for health research
Comply with the law	We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	We can share health information about you with organ procurement organizations We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address worker's compensation, law enforcement, and other government requests	We can use or share health information about you: For worker's compensation claims For law enforcement purposes or with law enforcement officials With health oversight agencies for activities authorized by law For special government functions such as military, national security, and presidential protective service
Respond to lawsuits and legal actions	We can share health information about in response to a court or administrative order, or in response to a subpoena

Our Responsibilities

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

- We will let you know promptly if a breach occurs that may have comprised the privacy or security of your information
- We must follow the duties and privacy practices described in this notice and give you a copy of it
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/notice-privacy-practices/index.html

How We Protect Your Protected Health Information

Health Plan is committed to protecting your PHI. We keep the PHI of our current and former members private and secure as required by law and accreditation standards. We follow these procedures to protect your PHI:

- We use physical and electronic safeguards.
- We regularly train our staff in the appropriate use and sharing of PHI.
- We secure our offices and lock our desks and filing cabinets.
- We protect our computers and electronic devices with passwords and only give access to PHI to staff that need it to do their jobs.
- Our Business Partners are also required to protect the privacy of any PHI we share with them, and they are not allowed to give PHI to others except as allowable by law, and by our Notice of Privacy Practices.

Changes to the Terms of This Notice

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

This Notice of Privacy Practices applies to:

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP
7751 South Manthey Road, French Camp, CA 95231

Contact our Compliance Department for any questions or concerns regarding your privacy at piu@hpsj.com or 1-888-361-7526 (TTY: 711) or visit www.hpsj-mvhp.org.

For More Information

Please contact us to request a copy of this notice in other languages or to get a copy in another format, such as large print or braille.

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 prefer a language other than English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Customer Service. This is a free service to you. We can also give you information in large print, braille, accessible electronic format or audio format. Call Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP to share your preferred language or format. We will ask if the request is for one document or for all.

If you request English, Spanish, Cambodian, Vietnamese, or other format for all documents, this is called a standing request. Your preference will be kept in our system for all future mailings and communications. You only have to request these options once. Requests for other languages must be made for each document.

To update your preference any time, call 1-888-361-7526 (TTY 711), 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. The call is free. For more information, visit www.hpsj-mvhp.org.

If you want information about any of the following, call Customer Service:

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers

  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - 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
  - limits to your coverage and drugs
  - 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:
  - put in writing why something isn't covered
  - change a decision we made
  - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network can't make you pay for covered services. They also can't balance bill or charge 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:*
  - For more information about when you can join a new MA or drug benefit plan.

- 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 can't make decisions for yourself.

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

The legal document 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 Customer Service to learn more.
- **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**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Customer Service for more information.

G3. What to do if your instructions aren't 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 California Department of Social Services State Hearings Division, P.O. Box 944243, Mail Station 21-37, Sacramento, CA 94244-2430. You can call their toll-free number at 1-800-743-8525 or 1-855-795-0634.

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 Customer Service 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:

- Customer Service.
- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. For more details about HICAP, refer to **Chapter 2** of this *Member Handbook.*
- 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 www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

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

- **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.
  - 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 Customer Service 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.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all the drugs you take. This includes drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP members,

Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.

- **Chapter 6** tells what you must pay for your drugs.
- **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** of this *Member Handbook* to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call Customer Service.
  - **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.
  - We can help you find out if you're moving outside our service area.
  - 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 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 Customer Service for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about 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 or TTY 711 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*.

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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 1-888-361-7526 (TTY 711) 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). HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP isn't connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-434-0222.

Help from the 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, TTY 711 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 a.m. and 5 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 **1-888-361-7526 (TTY: 711)** 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 impaired. The department's internet website **www.dmhc.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 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.dmhc.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**, Section F2,** 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:

- **Customer Service** at the numbers at the bottom of the page.
- **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.dmhc.ca.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.
    - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
    - Ask for a legal aid attorney from the 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 Customer Service at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at www.hpsj-mvhp.org. **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"
- **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 Customer Service 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.
   - 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: 1-888-361-7526 (TTY: 711).
- faxing: 1-209-762-4774.

- writing: Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP, 7751 South Manthey Road, French Camp, CA 95231.

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**:**

- 5 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 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** (How to make a complaint).

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

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

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 1-888-361-7526.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-888-361-7526.

- 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 or on our website at www.hpsj-mvhp.org.
- 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 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** *How to make a Complaint.*

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.

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, Section F4, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medi-Cal (Medicaid) service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. To file a State Hearing, refer to Section F4, 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 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 Section F4, 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 as the time is up. In California, a State Hearing is called if your doctor or other provider asks for a service that we won't approve, or we won't continue to pay for a service you already have. If the State Hearing is decided in your favor, we must give you the service you asked for. To file a State Hearing, refer to Section 4, 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.

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, Section G6.
- 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 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.

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 F3** 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.

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 acknowledgement 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.

(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. Refer to **Section F4** for more information on continuation of benefits during a Level 2 appeal.

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.

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 items or service**,** we must authorize or provide the service or items **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 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 items 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 items. You're never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for drug categories that require a copay.

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

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

G2. 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:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- 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** *Making a Level 1 Appeal* for information on making an appeal if we say **No**.

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-888-361-7526, 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** *Help with Coverage decisions and appeals* 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.
- You can also submit an exception request through the secure member portal.

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 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** *How to make a Complaint.*

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** *Making a Level 2 Appeal* 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** 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 1-888-361-7526 (TTY: 711), 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** *Asking for a coverage decision, including an exception* for more information.

We consider your appeal and give you our answer.

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

Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** *Making a Level 2 Appeal* 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** *Making a Level 2 Appeal* 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** *Making a Level 2 Appeal* for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **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 1-888-361-7526 (TTY: 711).
- 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** *Making a Level 2 Appeal* 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 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** Taking your appeal beyond level 2 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.

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're admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Customer Service 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 **doesn't** 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 Customer Service 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.

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, the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO). Call them at 1-877-588-1123. 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 Customer Service 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.
- 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 Customer Service 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 give 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.
- 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** *Taking your appeal beyond level 2* 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.

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'll 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 **doesn't** 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** How to Make a Complaint for more information about complaints.

- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Customer Service at the numbers at the bottom of the page.
  - Call the HICAP at 1-800-434-0222.
- **Contact the QIO.**
  - Refer to **Section H2** *Making a Level 1 Appeal* 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.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Customer Service 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.

I3. 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.

- 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'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care 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 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** *Taking your appeal beyond level 2* 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's favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (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.

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.
- 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.

Complaint	Example
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.
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 accommodation 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, Customer Service, 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.

Complaint	Example
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 1-888-361-7526.

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Customer Service at 1-888-361-7526 (TTY: 711). 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, Customer Service 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.
- We will send you a letter within five calendar days of receipt of your complaint. This letter will confirm it was received. A resolution letter will follow within 30 days of receipt of your complaint.

- You may have an urgent problem that involves an immediate and serious risk to your health. If this happens, you can request a "fast complaint." We will respond "fast complaints" within 72 hours.

> **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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan 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 hasn't 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're in severe pain, if you disagree with our plan's decision about your complaint, or if our plan hasn't 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:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights

  Department of Health Care Services office of Civil Rights

  P.O. Box 997413, MS 0009

  Sacramento, CA 95899 – 7413

Complaint forms are available at http://www/dhcs.ca.gov/Pages/Language_Access.aspx.

- Electronically: Send an email to Civilrights@dhcs.ca.gov

You may also have rights under the Americans with Disability Act (ADA) and under Section 1557 of the Affordable Care Act. You can contact the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

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** *Making a Level 1 Appeal* or refer to **Chapter 2** of this *Member Handbook*.

In California, the QIO is called **Commence Health, the Medicare Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)**. The phone number for Commence Health is 1-877-588-1123 (TTY 1-855-887-6668).

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*.

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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:

- Customer Service 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 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP. Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8 a.m. to 5 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

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 Customer Service 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 265.
- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8 a.m. to 6 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.

1. You can change to:	**Here is what to do:**
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.	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, TTY: 711 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.

2. You can change to:	Here is what to do:
Original Medicare with a separate Medicare drug plan, and a Medi-Cal Plan.	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, TTY: 711 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.

3. You can change to:	Here is what to do:
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/.	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, TTY: 711 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.

4. You can change to:	Here is what to do:
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**.	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, TTY: 711 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.

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 a.m. to 6 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 Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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.
  - If you move or take a long trip, call Customer Service 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.
  - You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.

- The Centers for Medicare & Medicaid Services (CMS) will notify us if you're not eligible to remain a member on this basis.
- We must disenroll you if you don't meet this requirement.

If you lose your Medi-Cal eligibility but can be expected to regain it within the *deeming period of* 5 month(s), we'll continue to provide all Medicare and Medi-Cal covered benefits. During this time, we'll assist you to regain Medi-Cal eligibility. If you can't regain Medi-Cal within *5* month(s), we'll disenroll you from Health Plan of San Joaquin/Mountain Valley Health Plan Advantage 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 Customer Service at the number at the bottom of this page.

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*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws 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:

- **By phone:** Call 1-888-361-7526. If you can't speak or hear well, please call 711 (Telecommunications Relay Service)
- **By Mail:** Fill out a complaint form or send a letter to:

  Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP
  Attention: Health Equity Officer
  7751 South Manthey Road
  French Camp, CA 92531

- **In person:** Visit your doctor's office or Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP and say you want to file a grievance.
- **Online:** Visit Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP's website at www.hpsj-mvhp.org.

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 Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service 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.

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 1-916-650-0590.

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 Customer Service.

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.

Balance billing: The practice where a provider bills a patient for the difference between the provider's full billed charges and the amount paid by the patient's health plan.

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 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 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 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.

Customer Service: 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 Customer Service.

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 six 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, 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 six months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're 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 Customer Service if you get any bills you don't understand.

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.

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 three-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").

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 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.

***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.

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. 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 FDA and serves as the comparison for manufacturers making a biosimilar version. It's 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

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*.

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 of 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. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. 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.

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).

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Customer Service

Type	Details
CALL	1-888-361-7526 Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30. Customer Service also has free language interpreter services available other than English.
TTY	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.
FAX	1-209-461-2550
WRITE	7751 S. Manthey Road French Camp CA 95231
WEBSITE	www.hpsj-mvhp.org

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1444. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

Health Plan of San Joaquin/Mountain Valley Health Plan Advantage D-SNP Customer Service

CALL **1-888-361-7526**

Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week from October 1 through March 31, and Monday to Friday from April 1 through September 30.

Customer Service also has free language interpreter services available for non-English speakers.

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Health Plan of San Joaquin

Mountain Valley Health Plan

Advantage D-SNP