2025 Member Handbook

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Central Health Medi-Medi Plan I (HMO D-SNP)

California H5649-002

Serving the following counties: Los Angeles, Riverside, Sacramento, San Bernardino and San Diego

Effective January 1 through December 31, 2025

Central Health Medi-Medi Plan I (HMO D-SNP) Member Handbook

01/01/2025 – 12/31/2025

Your Health and Drug Coverage under Central Health Medi-Medi Plan I (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook,* otherwise known as the *Evidence of Coverage,* tells you about your coverage under our plan through 12/31/2025*.* It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Central Health Medi-Medi Plan I (HMO D-SNP).

This document is available for free in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Spanish, Tagalog, and Vietnamese. You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-866-314-2427, TTY: 7118 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). The call is free.

> You can ask that we always send you information in the language or format you need. This is called a standing request. We will keep track of your standing request so you do not need to make separate requests each time we send you information.
>
> To get this document in a language other than English, please contact the State at (800) 541-5555, TTY: 711, Monday – Friday, 8 a.m. to 5 p.m., local time to update your record with the preferred language. To get this document in an alternate format, please contact Member Services at (855) 665-4627, TTY: 711, 7 days a week, 8:00 a.m. to 8:00 p.m., local time. A representative can help you make or change a standing request. You can also contact your Care Coordinator for help with standing requests.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

CALIFORNIA EAE

NOTICE OF AVAILABILITY

ATTENTION: If you need help in your language, call 1-855-665-4627 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1-855-665-4627 (TTY: 711). These services are free.

تنبيه: إذا كنت بحاجة إلى المساعدة بلغتك، فيُرجى الاتصال على الرقم 1-855-665-4627 (وبالنسبة لمستخدمي الهاتف النصي "TTY"، فيمكنهم الاتصال على: 711). كما تتوفر أدوات مساعدة وخدمات لذوي الاحتياجات الخاصة، مثل الوثائق بلغة برايل والطباعة بأحرف كبيرة. يُرجى الاتصال على الرقم 1-855-665-4627 (وبالنسبة لمستخدمي الهاتف النصي "TTY"، فيمكنهم الاتصال على: 711). هذه الخدمات مجانية.

ចំណាំ៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សូមទូរសព្ទទៅលេខ 1-855-665-4627 (TTY: 711)។ ជំនួយ និងសេវាកម្មសម្រាប់ជនដែលមានពិការភាព ដូចជាឯកសារជាអក្សរស្ទាបនិងជាពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ 1-855-665-4627 (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃនោះទេ។

請注意：如果您需要語言方面的協助，請撥打 1-855-665-4627 (TTY: 711)。我們也向身心障礙人士提供輔助及服務，例如點字與大字體文件。請撥打 1-855-665-4627 (TTY: 711)。這些服務均為免費

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Ձեր լեզվով օգնության դեպքում, զանգահարեք 1-855-665-4627 (TTY՝ 711) հեռախոսահամարով: Հաշմանդամների համար հասանելի են նաև աջակցման ծառայություններ, օրինակ՝ փաստաթղթեր բրայլյան և խոշոր տառերով: Զանգահարեք՝ 1-855-665-4627, (TTY՝ 711): Ծառայությունները գործում են անվճար:

ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਇੱਥੇ ਕਾਲ ਕਰੋ 1-855-665-4627 (TTY: 711). ਅਸਮਰਥਤਾਵਾਂ ਵਾਲੇ ਲੋਕਾਂ ਲਈ ਮਦਦ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ 1-855-665-4627 (TTY: 711). ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

THOV MUAB SIAB RAU: Yog koj xav tau kev pab ua koj hom lus, hu rau 1-855-665-4627 (TTY: 711). Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam rau cov neeg xiam oob qhab, xws li cov ntaub ntawv ua ntawv su thiab cov ntawv loj.Hu rau 1-855-665-4627 (TTY: 711). Lawv cov kev pab cuam yog muab pab dawb xwb.

注記：母国語によるサポートが必要な場合は、1-855-665-4627 (TTY：711) までご連絡ください。点字による文書や大きな活字で印刷した文書など、障がいのある方への支援やサービスもご利用いただけます。ご利用を希望される場合は、1-855-665-4627 (TTY：711)までご連絡ください。これらのサービスはいずれも無料です。

주의: 귀하의 언어로 도움이 필요하시면 1-855-665-4627(TTY: 711) 로 문의 바랍니다. 점자 및 큰 글자 문서와 같이 장애가 있는 사용자를 위한 지원 및 서비스도 제공됩니다. 1-855-665-4627(TTY: 711)로 문 의 바랍니다. 서비스 이용은 무료입니다.

ध्यान दें: यदि आपको अपनी भाषा में सहायता की आवश्यकता हो, तो 1-855-665-4627 (TTY: 711) पर कॉल करें। वविकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज जैसी सहायताएं और सेवाएं भी उपलब्ध हैं। 1-855-665-4627 (TTY: 711) पर कॉल करें। ये सेवाएं मुफ्त हैं।

UA ZOO SAIB: Yog tias koj xav tau kev pab ua koj hom lus, ces hu rau 1-855-665-4627 (TTY:711). Dhau li no lawm kuj muaj cov kev pab thiab cov kev pab cuam rau cov neeg uas muaj kev xiam oob qhab, xws li cov ntaub ntawv ua ntawv xuas thiab luam ua tus ntawv loj. Hu rau 1-855-665-4627 (TTY:711).Cov kev pab cuam no yog muab yam tsis xam nqi.

ຂໍ້ຄວນເອົາໃຈໃສ່: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ, ໃຫ້ໂທຫາ 1-855-665-4627 (TTY: 711). ນອກຈາກນີ້, ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສຳລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ ແລະ ຕົວພິມຂະໜາດໃຫຍ່. ໂທຫາເບີ 1-855-665-4627 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ແມ່ນຟຣີ.

توج ه : اگر میخواهید راهنماییها را به زبا ن خودتان دریافت کنی د، با شمار ه 1-855-665-4627 (شمار ه TTY: 711) تماس بگیرید . وسائل و خدمات کمک ی مخصوص افراد مبتال به معلولیت، مانند اسناد به خط بری ل و چاپ با حرو ف درشت نیز در دسترس هستند . برا ی دریافت این خدمات با شماره 1-855-665-4627 (شماره TTY: 711) تماس بگیرید . ای ن خدمات به صورت رای گان ارائه م ی شوند .

ВНИМАНИЕ! Если вам необходима информация на вашем языке, позвоните 1-855-665-4627 (TTY: 711). Для людей с инвалидностью также предоставляются услуги и информация в доступном формате — например, документы шрифтом Брайля или крупным шрифтом. Звоните 1-855-665-4627 (TTY: 711). Эти услуги предоставляются бесплатно.

ATENCIÓN: Si necesita ayuda en su idioma, llame al 1-855-665-4627 (TTY: 711). También están disponibles ayudas y servicios para personas con discapacidad, como documentos en braille y letra grande. Llame al 1-855-665-4627 (TTY: 711). Estos servicios son gratuitos.

PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1-855-665-4627 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumento sa braille at malalaking print. Tumawag sa 1-855-665-4627 (TTY: 711). Ang mga serbisyong ito ay libre.

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ โทร 1-855-665-4627 (TTY: 711) รวมถึงยังมีความช่วยเหลือและบริการสาหรับผู้พิการ เช่น เอกสารอักษรภาษาเบรลล์และตัวพิมพ์ใหญ่อีกด้วย โทร 1-855-665-4627 (TTY: 711) บริการเหล่านี้ไม่มีค่าใช้จ่าย

УВАГА! Якщо вам потрібна допомога вашою мовою, телефонуйте за номером 1-855-665-4627 (телетайп: 711). Крім того, ви можете отримати допоміжні засоби й послуги для осіб з особливими потребами, як-от документи, надруковані шрифтом Брайля або великим шрифтом. Телефонуйте за номером 1-855-665-4627 (телетайп: 711). Ці послуги безкоштовні.

CHÚ Ý: Nếu cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi 1-855-665-4627 (TTY: 711). Hiện chúng tôi cũng có sẵn các phương tiện hỗ trợ và dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi và chữ in cớ lớn. Hãy gọi 1-855-665-4627 (TTY: 711). Những dịch vụ này đều miễn phí.

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Disclaimers

- Coverage under Central Health Medi-Medi Plan I (HMO D-SNP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.
- Central Health Medi-Medi Plan I (HMO D-SNP) is a Health Plan with a Medicare Contract and a contract with the state Medicaid program. Enrollment in Central Health Medi-Medi Plan I (HMO D-SNP) depends on contract renewal.
- Eligibility for the Model Benefit or Rewards and Incentives (RI Programs under the Value-Based Insurance Design (VBID) Model is not assured and will be determined by the Medicare Advantage Organization (MAO) after enrollment, based on relevant criteria e.g., clinical diagnoses, eligibility criteria, participation in a disease state management program in the event eligibility of Targeted Enrollees for Model Benefits or RI Programs is not assured or cannot be determined before a Plan Year, as applicable.
- Central Health Medi-Medi Plan I (HMO D-SNP) to provide these benefits and/or lower copayments/ co-insurance as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

NONDISCRIMINATION NOTICE

Central Health Medi-Medi Plan I (HMO D-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

If you believe that Central Health Medi-Medi Plan I (HMO D-SNP) has discriminated on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with:

Civil Rights Coordinator

200 Oceangate, Long Beach, CA 90802

Phone: (866) 606-3889 Monday – Friday, 8 a.m. to 8 p.m., local time

TTY: 711

Fax: (562) 499-0610

Email: civil.rights@MolinaHealthcare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

Deputy Director, Office of Civil Rights
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

(800) 368-1019 (800) 537-7697 (202) 619-3818 OCRMail@hhs.gov

www.hhs.gov/ocr

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

If you believe that Central Health Plan has discriminated on the basis of race, color, national origin, disability, age, or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue SW, Room 509F HHH Building

Washington, DC 20201

1–800–868–1019 or 800–537–7697 (TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

Chapter 1: Getting started as a member

Introduction

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

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A. Welcome to our plan

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

At Central Health Plan, we understand every member is different and has unique needs. That is why Central Health Medi-Medi Plan I (HMO D-SNP) combines your Medicare and Medi-Cal benefits into one plan, so you can have personalized assistance and peace of mind.

In 2025, Central Health Plan is proud to offer an integrated Medicare and Medi-Cal experience to bring quality health care to more people – especially those who need it most. From the beginning, Central Health Medi-Medi Plan I (HMO D-SNP) has put the needs of our members first, and we continue to do this today.

Welcome to Central Health Plan. Your extended family.

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 is not affected.

C. Advantages of our plan

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

We help make your Medicare and Medi-Cal benefits work better together 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 Central Health Medi-Medi Plan I (HMO D-SNP): In most instances you will be enrolled in Central Health Medi-Medi Plan I (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Central Health Medi Medi Plan I (HMO DSNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Central Health Medi-Medi Plan I (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at 1-866-314-2427, TTY: 711 if you have any questions.

D. Our plan's service area

Our service area includes these counties in California:

- Los Angeles; Riverside; Sacramento; San Bernardino; San Diego Only people who live in our service area can join our plan.

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

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- are age 21 and older at the time of enrollment, **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for Medi-Cal.

If you lose Medi-Cal eligibility but can be expected to regain it within 3 month(s), then you are still eligible for our plan.

Call Member Services 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 reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, even if they are not in our network. We call this continuity of care. If they are not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
  - We determine an existing relationship by reviewing your available health information 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 1-866-314-2427, TTY: 711.If you are at risk of harm, we must respond within 3 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 rental and have a network provider deliver the rental. Although you cannot

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 will need to use doctors and other providers in the Central Health Medi-Medi Plan I (HMO D-SNP) network that are affiliated with your primary care provider's medical group, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Our plan's PCPs are affiliated with IPAs and medical groups. When you choose your PCP, you are also choosing the affiliated IPA or medical group. This means that your PCP will be referring you to specialists and services that are also affiliated with his or her IPA or medical group. An IPA or Medical Group is an association of PCPs and specialists created to provide coordinated healthcare services to you. Refer to **Chapter 3** of your *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

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

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

G2. Care plan

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

Your care plan includes:

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

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

H. Your monthly costs for Central Health Medi-Medi Plan I (HMO D-SNP)

Your costs may include the following:

- Plan premium (**Section H1**)
- Monthly Medicare Part B Premium (**Section H2**)
- Medicare Prescription Payment Plan Amount (**Section H3**)

In some situations, your plan premium could be less.

H1. Plan premium

As a member of your plan, you pay a monthly plan premium. For 2025, the monthly premium for Central Health Medi-Medi Plan I (HMO D-SNP) is $13.60. Depending on your level of “Extra Help” subsidy, your $13.60 monthly premium may be reduced to $0.

H2. Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some members are required to pay other Medicare premiums. As explained in Section E above, in order to be eligible for our plan, you must maintain your eligibility for Medi-Cal as well as have both Medicare Part A and Medicare Part B. For most *Central Health Medi-Medi Plan I (HMO D-SNP* members, Medi-Cal pays for your Medicare Part A premium (if you don’t qualify for it automatically) and for your Medicare Part B premium.

If Medi-Cal is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan. This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren’t eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

details.

H3. Medicare Prescription Payment Amount

If you’re participating in the Medicare Prescription Payment Plan, you’ll get a bill from your plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month’s balance, divided by the number of months left in the year.

Chapter 2 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.

I. Your Member Handbook

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

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

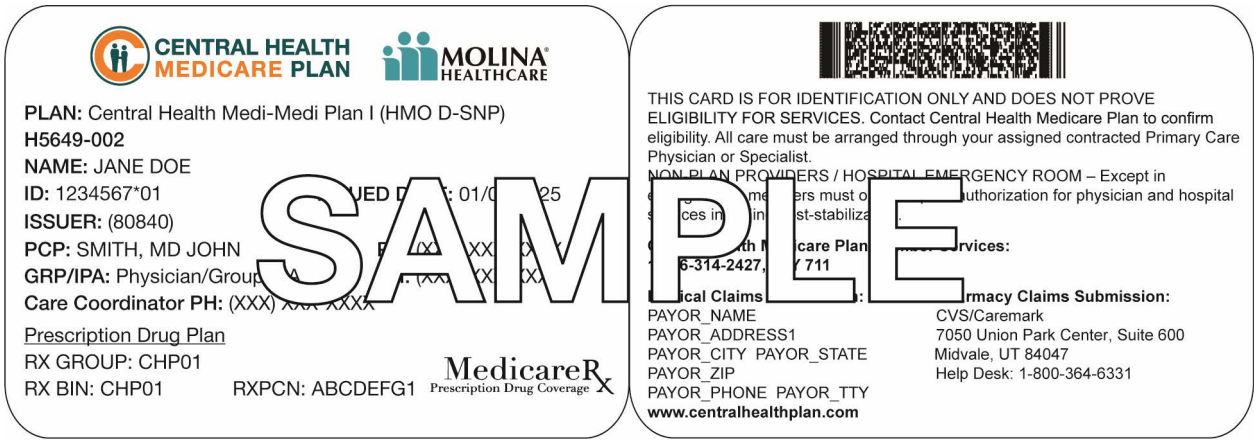
The contract is in effect for the months you are enrolled in our plan between 1/1/2025 and 12/31/2025.

J. Other important information you get from us

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

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services, including 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 Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card 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. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

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

- Acupuncture
- Aids waiver program
- Ambulance services
- Audiological services
- Behavioral Health Treatment (BHT)
- Blood and blood derivatives
- Cardiac and Pulmonary
- Certified family nurse practitioner
- Chiropractic
- Chronic dialysis services
- Community-Based Adult Services (CBAS)

- Comprehensive Perinatal Service Program (preventive services)
- Dental
- Diagnostic x-ray
- Dialysis
- Durable medical equipment (DME) and related supplies
- Doctors visits
- Early & Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Emergency care
- Enteral Formula
- Family planning services and supplies
- Federal qualified health center services (FQHC)
- Hearing
- Home and Community care for functionally disabled elderly (waiver only)
- Home health agency services
- Home health aide services
- Hospice
- Inpatient hospital
- Intermediate care facility
- Kidney disease and conditions
- Laboratory, radiological and radioisotope services
- Licensed midwife services
- Meals
- Non-Emergency Medical transportation Nurse anesthetist services
- Outpatient mental health
- Outpatient prescription drugs
- Outpatient rehabilitation
- Outpatient services
- Personal care services
- PERS- Personal Emergency Response System
- Podiatry
- Preventative services
- Prosthetic devices
- Psychology services
- Rural Health clinic Services (RHC)
- Sign language interpreter services
- Skilled nursing facility
- Special duty nursing services
- Transplants
- Transportation/Non transportation services
- Urgently needed services
- Vision
- Asthma preventive services

- Dental services
- Doula services

This may not be a fully inclusive list. You can find the list of benefits covered outside of our plan in Chapter 4, Section F.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days.

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

This directory lists the Primary Care Doctors (PCPs), hospitals, and other health care providers that are available to you as a member of Central Health Plan. You can also find the following information about Central Health Plan doctors and other health care providers in your Provider Directory:

- Names
- Addresses
- Telephone numbers
- Languages spoken
- Availability of service locations
- Hospital Privileges/Affiliations
- Medical Group

It is important that patients are able to see doctors easily, and that doctors' offices provide any help they need to get care. Physical accessibility information is listed for:

- Basic Access
- Limited Access

We also use the following accessibility indicator symbols in our Provider Directories to show the other areas of accessibility at a provider office:

- P = Parking
- EB = Exterior Building
- IB = Interior Building
- W = Waiting Room
- R = Restroom
- E = Exam Room
- T = Exam Table
- S = Wheelchair Weight Scale

You can also find out whether or not a provider (doctors, hospitals, specialists, or medical clinics) is accepting new patients in your Provider Directory or online via our website listed at the bottom of this page.

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

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "*Drug List*" for short. It tells you which prescription drugs our plan covers.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Member Handbook* for more information.

Each year, we send you information about how to access the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take **Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

K. Keeping your membership record up to date

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

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

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and,**
- if you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

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

K1. Privacy of personal health information (PHI)

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

Chapter 2: Important phone numbers and resources

Introduction

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

Table of Contents

A. Member Services

CALL	1-866-314-2427 This call is free. 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). Assistive technologies, including self-service and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. Monday - Friday, 8:00 a.m. to 8:00 p.m., local time.
FAX	For Medical Services: Fax: (310) 507-6186 For Part D (Rx) Services: Fax: (866) 290-1309
WRITE	For Medical Services: 200 Oceangate, Suite 100, Long Beach, CA 90802 For Part D (Rx) Services: 7050 Union Park Center, Suite 200 Midvale, UT 84047
WEBSITE	www.centralhealthplan.com

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**
    - the amount we pay for your health services.
  - Call us if you have questions about a coverage decision about your health care.
  - To learn more about coverage decisions, refer to **Chapter 9** of your *Member Handbook*.
- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Member Services.
- 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 1-866-314-2427, TTY: 711
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).

  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can make a complaint about our plan to the Medicare Medi-Cal Ombuds Program by calling 1-855-501-3077.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *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 prescription drugs, refer to **Chapter 9** of your *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 prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.

B. Your Care Coordinator

The Central Health Medi-Medi Plan I (HMO D-SNP) care coordinator is your main contact. This person helps you manage all of your providers, services and makes sure you get what you need. The care coordinator helps coordinate all Medicare and Medicaid covered services, including state programs such as HCBS and care model that integrates your physical health, behavioral health, and social determinates of health. You and/or your caregiver may request a change in the care coordinator assigned, as needed, by calling the care coordinator or Member Services. Additionally, Central Health Medi-Medi Plan I (HMO D-SNP) staff may make changes to your care coordinator assignment based upon your needs (cultural / linguistic / physical / behavioral health) or location. Contact Member Services for more information.

CALL	1-866-314-2427 This call is free. 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30) Assistive technologies, including self-services and voicemail options, are available on holidays, after regular business hours and on Saturdays and Sundays. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. Monday – Friday, 8 a.m. to 8 p.m., local time.
WRITE	200 Oceangate, Suite 100, Long Beach, CA 90802
WEBSITE	www.centralhealthplan.com

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

- Community-Based Adult Services (CBAS)
- skilled nursing care
- physical therapy
- occupational therapy
- speech therapy
- medical social services
- 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) gives free health insurance counseling to people with Medicare. 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 not connected with any insurance company or health plan.

CALL	**Los Angeles County:** (213) 383-4519 Monday – Friday, 8:30 a.m. to 4:30 p.m., local time. **Riverside and San Bernardino Counties:** (909-256-8369 Monday – Friday, 9 a.m. to 4 p.m., local time. **Sacramento County:** 1-800-434-0222 Monday – Friday: 9 a.m. – 4 p.m. (Lunch 12-1:30), local time. **San Diego County:** (858) 565-8772, office – San Diego (760) 353-0223, office – Imperial
TTY	*711*
WRITE	**Los Angeles County:** Center for Health Care Rights 520 S. Lafayette Park Place, Suite 214 Los Angeles, CA 90057 **Riverside and San Bernardino Counties:** HICA Informaton 2280 Market Street, Suite 140 Riverside, CA 92501 **Sacramento County:** Legal Services of Northern California, Inc. 505 12th Street Sacramento, CA 95814 **San Diego County:** Elder Law & Advocacy 5151 Murphy Canyon Road, Suite 100 San Diego, CA 92123
WEBSITE	http://www.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,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Nurse Advice Call Line

You can call Central Health Plan's Nurse Advice Line 24 hours a day, 365 days a year. The service connects you to a qualified nurse who can give you health care advice in your language and help direct you to where you can get the care that is needed. Our Nurse Advice Line is available to provide services to all Central Health Plan Members across the United States. The Nurse Advice Line is a Utilization Review Accreditation Commission (URAC)-accredited health call center. The URAC accreditation means that our nurse line has demonstrated a comprehensive commitment to quality care, improved processes and better patient outcomes. Our Nurse Advice line is also certified by National Committee for Quality Assurance (NCQA) in Health Information Products (HIP) for our 24/7/365 Health Information Line. NCQA is designed to comply with NCQA health information standards for applicable standards for health plans.

Nurse Advice Line will assess your safety, link you to emergency services, find a behavioral health provider and community resources, and refer you to a Central Health Medi-Medi Plan I (HMO D-SNP) care coordinator. For more information, you can call Central Health Medi-Medi Plan I (HMO D-SNP) at the phone number at the bottom of the page.

You should call the Nurse Advice Line if you need help right away or are not sure of what to do. If you have an emergency that may cause harm or death to you or others, go to the nearest hospital emergency room OR call 911.

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

CALL	1-866-314-2427 This call is free. Days and hours of operation We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

E. Behavioral Health Crisis Line

CALL	**For Los Angeles County:** Los Angeles County Department of Mental Health 1-800-854-7771 (24/7 Help Line) - TTY: 711 **For Riverside County:** Riverside University Health System – Behavioral Health 1-800-499-3008 **For Sacramento County:** Mental health 24-Hour Crisis Line 1-888-881-4881 – TTY: 711 **For San Bernardino County:** San Bernardino County Department of Behavioral Health 1-888-743-1478 (24-hour Helpline) or 1-800-968-2636 (substance use disorder 24-hour helpline) **For San Diego County:** San Diego Behavioral Health Services 1-888-724-7240 (24/7 Access & Crisis Line) - TTY: 711

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

CALL	(877) 588-1123
TTY	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	https://livantaqio.com/en/states/california

Contact Livanta 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,
  - 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.

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 This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

H. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, 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 are enrolled in Medicare and in Medi-Cal. If you have questions about your Medi-Cal benefits, call your plan care coordinator. If you have questions about Medi-Cal plan enrollment, call Health Care Options.

CALL	1-800-430-4263 Monday through Friday, 8 a.m. to 6 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov/

I. Medi-Cal Managed Care and Mental Health Office of the Ombudsman

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

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

J. County Social Services

If you need help with your In-Home Support Services (IHSS) benefits, contact your local County Social Services agency. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities. To apply for IHSS, contact your local county IHSS Office.

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

Contact your county social services agency for any questions about your Medi-Cal eligibility.

CALL	**Riverside County:** (877) 410-8827 Monday - Friday from 8 a.m. - 5 p.m., local time. This call is free. **Los Angeles County:** (888) 822-9622 Monday - Friday from 8 a.m.- 5 p.m., local time **Sacramento County:** (916) 874-9471 Monday – Friday 9:00 a.m. – 4:00 p.m., local time **San Bernardino County:** (909) 387-4544 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time **San Diego County:** Within San Diego County: (800) 510-2020 This call is free Outside San Diego County: (800) 339-4661 This call is free. Monday - Friday, 8 a.m. to 5 p.m., local time.
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	**Los Angeles County Department of Public Social Services** 2707 South Grand Avenue, Los Angeles, CA 90007 **County of Riverside In-Home Supportive Services** 12125 Day Street, S-101, Moreno Valley, CA 92557 **County of Sacramento In-Home Supportive Services** PO Box 268131, Sacramento, CA 95826 **County of San Bernardino In-Home Supportive Services** 686 E. Mill Street, 2nd Floor, San Bernardino, CA 92414-0640 **Health and Human Services Agency County of San Diego In-Home Supportive Services** 1600 Pacific Highway, Room 206, San Diego, CA 92101
WEBSITE	www.cdss.ca.gov/inforesources/county-ihss-offices

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.

CALL	**Los Angeles County Department of Mental Health:** (800) 854-7771 This call is free. 24 hours a day, 7 days a week **Riverside University Health Systems Behavioral Health- Community Access and Referral, Evaluation, and Support Line (CARES):** (800) 499-3008 This call is free. Monday - Friday 8 a.m. - 5:30 p. m., local time. **Sacramento County Mental Health Services** (888) 881-4881 Monday - Friday, 8 am - 5 pm (24/7 for Mental Health Crisis Calls) **San Bernardino - Department of Behavioral Health:** (888) 743-1478 This call is free. 24 hours a day, 7 days a week **San Diego - Mental Health Services:** (888) 724-7240 This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday - Friday, 8:00 a.m. to 8:00 p.m., local time.

Contact the county Behavioral Health agency for help with:

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

L. California Department of Managed Health Care

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

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

M. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

M1. Extra Help

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

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

N. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S. Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, 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

O. 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 receive Medicare through the RRB, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with a 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. If you press "1", you may access the automated RRB Help Line and 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 are *not* free.
WEBSITE	www.rrb.gov

P. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse's or domestic partner's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Q. Other resources

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

R. Medi-Cal Dental Program

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

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

Dental benefits are available through Medi-Cal Dental Fee-for-Service (FFS), Dental Managed Care (DMC) Programs and Health Plan of San Mateo.

CALL	1-800-322-6384 The call is free. Medi-Cal Dental FFS Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday.
TTY	1-800-735-2922 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.dental.dhcs.ca.gov smilecalifornia.org

Instead of the Medi-Cal Dental Fee-For-Service Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Sacramento and Los Angeles Counties. If you want more information about dental plans, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free. DMC contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

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

Introduction

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

Table of Contents

A. Information about services and providers

Services are health care, 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 your Member Handbook. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your Member Handbook.

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain 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 Medi-Cal covered services, including state programs such as home-and community-based services (HCBS), long-term services and support (LTSS) and long-term institutional care provided through Medi-Cal programs.

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 a **plan benefit.** This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, your network PCP or our plan must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services.
  - Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is s an association of PCPs and specialists created to provide coordinated health care services to you.
  - You do not need a referral from your PCP for emergency care or urgently needed care, to use a woman's health provider, or for any of the other services listed in section D1 of this chapter.
- **You must get your care from network providers that are affiliated with your PCP's medical group**. Usually, we won't cover care from a provider who doesn't work with our health plan and your PCP's medical group. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:

- We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to **Section H** in this chapter).
- If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. Prior authorization should be obtained before seeking care. In this situation, we cover the care as if you got it from a network provider.
- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. The cost-sharing you pay for dialysis can never exceed the cost-sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost-sharing for the dialysis may be higher.
- When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network that are affiliated with your PCP's medical group. After 12 months, we will no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's medical group.

New members to Central Health Medi-Medi Plan I (HMO D-SNP): In most instances, you will be enrolled in Central Health Medi-Medi Plan I (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Central Health Medi-Medi Plan I (HMO DSNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Central Health Medi-Medi Plan I (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at 1-866-314-2427, TTY: 711 if you have any questions.

C. Your care coordinator

C1. What a care coordinator is

A Central Health Medi-Medi Plan I (HMO D-SNP) care coordinator is a main person for you to contact to assist you with your care, if required. This person helps to coordinate your care and manage your services to ensure you receive the help that you require. They also help coordinate all Medicare and Medi-Cal covered services, including state programs such as HCBS and a care model that integrates your physical health, behavioral health, and social determinates of health.

C2. How you can contact your care coordinator

If you want to contact your care coordinator, please call Member Services 1-866-314-2427, TTY: 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). Or visit www.centralhealthplan.com.

C3. How you can change your care coordinator

You may request a change in care coordinator by calling care coordination or Member Services. Central Health Medi-Medi Plan (HMO D-SNP) staff may make changes to member case manager assignment based on member needs or location.

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 are also choosing the affiliated medical group.

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

Primary Care Provider (PCP) is a physician, nurse practitioner, or health care professional and/or medical home or clinic (Federally Qualified Health Centers - FQHC) who gives you routine health care. Central Health Medi-Medi Plan (HMO D-SNP) maintains a network of specialty providers to care for its members. Referrals from a Central Health Medi-Medi Plan (HMO D-SNP) PCP are required for a member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral services. Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- Your X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions
- Follow-up care

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

A medical group/IPA is a network of independent doctors who own and operate their own practices (instead of being employees of a larger healthcare system). These doctors join a medical group so they can stay independent while getting the support they need to take care of patients.

Your choice of PCP

Your relationship with your PCP is an important one. We strongly recommend that you choose a PCP close to home. Having your PCP nearby makes receiving medical care and developing a trusting and open relationship easier. For a copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a PCP, please contact Member Services. If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. Once you have chosen your PCP, we recommend that you have all your medical records transferred to his or her office. This will provide your PCP access to your medical history and make him

or her aware of any existing health care conditions you may have. Your PCP is now responsible for all your routine health care services, so he or she should be the first one you call with any health concerns. The name and office telephone number of your PCP is printed on your membership card. If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the *Provider and Pharmacy Directory* or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.

Option to change your PCP

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

Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.

You can change your PCP at any time. In most cases, changes will be in effect the first day of the following calendar month. There may be exceptions if you're currently receiving a treatment at the time of your PCP change request. Contact Member Services for more information about any of our Central Health Plan providers and request the PCP change. For some providers, you may need a referral from your PCP (except for emergent and out of area urgent care services).

Services you can get without approval from your PCP

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

- emergency services from network providers or out-of-network providers
- urgently needed care from network providers
- urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area)

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

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. If you call Member Services before you leave the service area, we can help you receive dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are an American Indian Member, you may obtain Covered Services from an Indian Health Care Provider of your choice, without requiring a referral from a Network PCP or Prior Authorization.
- Nurse Midwife Services, Family Planning, HIV Testing & Counseling, Treatment for Sexually Transmitted Diseases (STD's)

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.
- Gastroenterologists care for patients with digestive or intestinal problems.
- Nephrologists care for patients with kidney problems.

Urologists care for patients with urinary and bladder problems. As a member you are not limited to specific specialists. Central Health Medi-Medi Plan I (HMO D-SNP) maintains a network of specialty providers to care for its members. Referrals from your PCP may be required to receive specialty services, members are allowed to directly access women health specialists for routine and preventive health without a referral services. For some services you may be required to get a Prior Authorization. Your PCP may request a prior authorization from Central Health Plan's Utilization Management Department by telephone, fax, or mail based on the urgency of the requested service.

Please refer to the Benefits Chart in Chapter 4 for information about which services require prior authorization.

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

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

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

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

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

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.

- We will 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 will notify you if you have seen that provider within the past three years.
  - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. Prior Authorization may be required.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)
- If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care.
- If you find out one of your providers is leaving our plan, call Member Services at the numbers listed at the bottom of this page. We can assist you in finding a new provider and managing your care.

D4. Out-of-network providers

Out-of-network providers are providers that do not have an agreement to work with Central Health Plan. Except for emergency care, family care, sensitive care, and care pre-approved by Central Health Plan, you might have to pay for any care you get from out-of-network providers in your service area.

If you need medically necessary health care services that are not available in the network, you might be able to get them from an out-of-network provider for free. Central Health Plan may approve a referral to an out-of-network provider if the services you need are not available innetwork or are located very far from your home. If we give you a referral to an out-of-network provider, we will pay for your care.

For urgent care inside the Central Health Plan service area, you must go to a Central Health Plan in-network urgent care provider. You do not need pre-approval (prior authorization) to get urgent care from an in-network provider. You do need to get pre-approval (prior authorization) to get urgent care from an out-of-network provider inside the Central Health Plan service area.

If you get urgent care from an out-of-network provider inside Central Health Plan service area, you might have to pay for that care.

Outside the service area

If you are outside of the Central Health Plan service area and need care that is not an emergency or urgent, call your PCP right away.

For emergency care, call 911 or go to the nearest emergency room. Central Health Plan covers out-of-network emergency care. If you travel to Canada or Mexico and need emergency care requiring hospitalization, Central Health Plan will cover your care.

If you are in another state or are in a United States Territory such as American Samoa, Guam, Northern Mariana Islands, Puerto Rico, or United States Virgin Islands, you are covered for emergency care. Not all hospitals and doctors accept Medicaid. (Medi-Cal is what Medicaid is called in California only.) If you need emergency care outside of California, tell the hospital or emergency room doctor as soon as possible that you have Medi-Cal and are a member of Central Health Plan.

Ask the hospital to make copies of your Central Health Plan ID card. Tell the hospital and the doctors to bill Central Health Plan. If you get a bill for services you got in another state, call Central Health Plan right away. We will work with the hospital and/or doctor to arrange for Central Health Plan to pay for your care.

If you are outside of California and have an emergency need to fill outpatient prescription drugs, have the pharmacy call Medi-Cal Rx at 1-800-977-2273.

Note: American Indians may get services at out-of-network IHCPs.

If you have questions about out-of-network or out-of-service-area care, call 1-866-314-2427, (TTY, 711). If the office is closed and you want help from a Central Health Plan representative, call the Nurse Advice Line at 1-888-920-8809.

If you need urgent care out of the Central Health Plan service area, go to the nearest urgent care facility. If you are traveling outside the United States and need urgent care, Central Health Plan will not cover your care. For more on urgent care, read "Urgent care" later in this chapter.

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

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. 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.

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

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan does not provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through the county mental health plan for your county:

- Los Angeles County Department of Mental Health

- Riverside University Health System – Behavioral Health
- Sacramento County Mental Health Plan
- San Bernardino County Department of Behavioral Health
- San Diego County – Behavioral Health Services

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 Riverside University Health System – Behavioral Health, Sacramento County Mental Health Plan, San Bernardino County Department of Behavioral Health, San Diego County-Behavioral Health Services and Los Angeles County Department of Public Health include:

- mental health services
- medication support services
- day treatment intensive
- day rehabilitation
- crisis intervention
- crisis stabilization
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- 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 Organized Delivery System services are available to you through your county mental health plan for Riverside, Sacramento, San Diego, and San Bernardino counties or for Los Angeles County, the Los Angeles County Department of Public Health if you meet criteria to receive these services. Drug Medi-Cal services provided by your county mental health plan 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

Drug Medi-Cal Organized Delivery System 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

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

Central Health Medi-Medi Plan I (HMO D-SNP) provides access to many mental health and substance use providers. A list of providers can be located on the Central Health Medi-Medi Plan I (HMO D-SNP) Member website or by calling Member Services. For a copy of the most current Provider/Pharmacy Directory, or to seek additional assistance in choosing a behavioral health provider, please contact Member Services.
For some services you may be required to get a Prior Authorization. You or your Behavioral Health Provider or your PCP may request a prior authorization from Central Health Plan's Utilization Management Department by telephone, fax, or mail based on the urgency of the requested service.

Please refer to the Benefits Chart in Chapter 4 for information about which services require prior authorization. The care must be determined necessary. By necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current mental health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of behavioral health and medical practice.

If you are receiving services or need to obtain Medi-Cal specialty mental health services or drug services that are available to you through the county mental health plan (MHP), Central Health Medi-Medi Plan I (HMO D-SNP) care coordinators can help refer you to the appropriate county resource for an assessment. You can call Member Services to request assistance. You can also contact the County directly. See the appropriate county numbers in the information below.

Specialty Mental Health Services
Los Angeles County Department of Mental Health 1-800-854-7771
Riverside University Health System – Behavioral Health 1-800-499-3008
Sacramento County Mental Health Plan – 1-916-875-2400
San Bernardino County Department of Behavioral Health 1-888-743-1478
San Diego County Behavioral Health Services 1-888-724-7240

Drug Medi-Cal Services
Los Angeles County Department of Public Health 1-844-804-7500
Riverside University Health System – Behavioral Health 1-800-499-3008
Sacramento County Mental Health Plan – 1-916-875-2400
San Bernardino County Department of Behavioral Health 1-888-743-1478
San Diego County Behavioral Health Services 1-888-724-7240

G. Transportation services

G1. Medical transportation of non-emergency situations

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

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

Non-emergency medical transportation must be used when:

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

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Central Health Medi-Medi Plan I (HMO D-SNP) at call Member Services at the phone number printed at the bottom of this page at least two business days 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

Central Health Medi-Medi Plan I (HMO D-SNP) covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation will not be provided if Medicare or Medi-Cal does not cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, Central Health Medi-Medi Plan I (HMO D-SNP) will help you schedule your transportation. A list of covered services is in Chapter 4 of this handbook. Transportation is not covered outside Central Health Medi-Medi Plan I (HMO D-SNP)'s network or service area unless pre-authorized.

G2. Non-medical transportation

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

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

Central Health Medi-Medi Plan I (HMO D-SNP) allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. Central Health Medi-Medi Plan I (HMO D-SNP) uses Non-Emergency Medical Transportation (NEMT) to arrange for non-medical transportation. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Central Health Medi-Medi Plan I (HMO D-SNP) must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You cannot be reimbursed for driving yourself.**

Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call Central Health Medi-Medi Plan I (HMO D-SNP) Member Services at the numbers listed at the bottom of this page at least two business days 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

Central Health Medi-Medi Plan I (HMO D-SNP) provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

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

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

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

- serious risk to your health or to that of your unborn child; **or**

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

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license.

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.

You can find the number to Member Services at the bottom of this page.

Covered services in a medical emergency

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your Member Handbook.

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

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

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

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

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules 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

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

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

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

Urgently needed care outside our plan's service area

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

Our plan does not cover urgently needed care or any other non-emergency care that you get outside the United States.

Our plan covers worldwide emergency and urgently needed care services outside the United States under the following circumstances:

You are covered for worldwide emergency, urgent care services, and emergency transportation services up to $100,000 each calendar year. For more information, refer to the benefits chart in Chapter 4.

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 are still entitled to care from our plan.

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

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 prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

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

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

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

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

I1. What to do if our plan does not cover services

Our plan covers all services:

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

If you get services that our plan does not cover, **you pay the full cost yourself**, unless it is 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 will not pay for your services, you have the right to appeal our decision.

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

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

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

J1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

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

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

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

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

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you will 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 is part of the research study
- treatment of any side effects and complications of the new care

If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves. If you're part of a study that Medicare or our plan has **not** 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/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

K. How your health care services are covered 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 are against getting medical treatment that is "non-excepted."

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.

Our plan covers an unlimited number of days for an inpatient hospital stay. (See the Benefits Chart in Chapter 4).

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you usually will **not** own DME, no matter how long you rent it.

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

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

L2. DME ownership if you switch to Original Medicare

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

Note: You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You* 2025 handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

If Medi-Cal is not elected, you will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or 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 do not count toward the payments you need to make after leaving our plan.**

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the 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 and you're a member of our plan, we cover:

- rental of oxygen equipment

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

Oxygen equipment must be returned 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.

If oxygen equipment is medically necessary **after you rent it for 36 months,** your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

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

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

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 your *Member Handbook*.

New members to Central Health Medi-Medi Plan I (HMO D-SNP): In most instances you will be enrolled in Central Health Medi-Medi Plan I (HMO D-SNP) for your Medicare benefits the 1st day of the month after you request to be enrolled in Central Health Medi-Medi Plan I (HMO D-SNP). You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Central Health Medi-Medi Plan I (HMO D-SNP). There will be no gap in your Medi-Cal coverage. Please call us at 1-866-314-2427, TTY: 711 if you have any questions.

Table of Contents

A. Your covered services

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

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

If you need help understanding what services are covered, call your care coordinator or Member Services at 1-866-314-2427, TTY: 711.

A1. During public health emergencies

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 are still entitled to care from Central Health Medi-Medi Plan I (HMO D-SNP).

Please call Member Services for information on how to obtain needed care during a disaster.

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 your *Member Handbook* or call Member Services.

C. About our plan's Benefits Chart

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

We pay for the services listed in the Benefits Chart when the following rules are met.

You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We 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, home and community-based services (HCBS), 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, the plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization 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 receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.
- 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 in italic type.
- If your 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.
- If you lose your Medi-Cal benefits, within 90 days of deemed continued eligibility, your Medicare benefits in this plan will continue. However, your Medi-Cal service may not be covered. Contact your county eligibility office or Health Care Options for information about your Medi-Cal eligibility. You can keep your Medicare benefits, but not your Medi-Cal benefits.

Important Benefit Information for Members with Certain Chronic Conditions.

- If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits
  - Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder)
  - Chronic heart failure
  - Dementia
  - Diabetes
  - Chronic lung disorders
  - Kidney disease

Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.

- Please contact us for additional information.

Most preventive services are free. You will find this apple  next to preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

Services that our plan pays for		What you must pay
	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0 There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. *Prior Authorization may be required.* *Referral may be required.*
	Acupuncture We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are 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; **and** • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse.	$0 You pay $0 for each Medicare-covered treatment *Prior Authorization may be required.* *Referral may be required.*
	Acupuncture – Routine Unlimited acupuncture visits per year.	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. *Prior Authorization may be required.* *Referral may be required.*
	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 are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	You pay $0 for each Medicare-covered one-way ambulance trip. **Prior authorization is only required for non-emergent ambulance transport.** If you need emergency care, dial 911 and request an ambulance. Refer to "Worldwide emergency/ urgent coverage" in this chart if you need emergency ambulance transport outside the U.S.
	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 **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	$0 There is no coinsurance, copayment, or deductible for the annual wellness visit. *Prior Authorization may be required.* *Referral may be required.*
	Asthma Preventive Serivces You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.	$0

Services that our plan pays for		What you must pay
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	$0 There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. *Prior Authorization may be required.* *Referral may be required.*
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and over • clinical breast exams once every 24 months	$0 There is no coinsurance, copayment, or deductible for covered screening mammograms. *Prior Authorization may be required.* *Referral may be required.*
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0 *Prior Authorization may be required.* *Referral may be required.*
	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 are eating well.	$0 There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	**Cardiovascular (heart) disease testing** We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0 There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. *Prior Authorization may be required.* *Referral may be required.*
	**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 5 years	$0 There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. *Prior Authorization may be required.* *Referral may be required.*
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment	You pay $0 per visit for these Medicare-covered chiropractic services. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	**Colorectal cancer screening** We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.	$0 There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. *Prior Authorization may be required.* *Referral may be required.*
	Dental services (Medicare-covered) We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we do not cover is available through Medi-Cal Dental, described in F2 below. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	$0 *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	Dental services (Medi-Cal) Certain dental services are available through Medi-Cal Dental; includes but is not limited to, services such as: • Initial examinations, X-rays, cleanings, and fluoride treatments • Restorations and crowns • Root canal therapy • Partial and complete dentures, adjustments, repairs, and relines The majority of Dental benefits are available through Medi-Cal Dental Fee-for-Service (FFS) and Dental Managed Care (DMC) delivery systems. For more information: Call: 1-800-322-6384 • The call is free. Medi-Cal Dental FFS representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. TTY: 1-800-735-2922 • This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Website: http://www.dental.dhcs.ca.gov or SmileCalifornia.org In addition to Medi-Cal Dental Fee-For-Service, you may get dental benefits through a Dental Managed Care plan. Dental Managed Care plans are available in Sacramento and Los Angeles counties. If you want more information about dental plans, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free. Dental Managed Care contacts are also available here: https://dental.dhcs.ca.gov/Contact_Us/DMC_Member_Contact_Information/DMCMemberContactInformation.	$0

Services that our plan pays for		What you must pay
	Dental services (Supplemental) In addition, we cover: Preventive Dental (e.g. Oral exam, x-rays, cleanings) • Oral Exams, limit 2 every year: You pay a $0 copay • Prophylaxis (Cleaning), limit 2 every year: You pay a $0 copay • Fluoride Treatment, limit 2 every year: You pay a $0 copay • Dental X-Rays: You pay a $0 copay Comprehensive Services: • Adjunctive General Services: You pay a $0 copay • Restorative Services: You pay a $0 copay • Endodontics: You pay a $0 copay • Periodontics: You pay a $0 copay • Prosthodontics, removable: You pay a $0 copay • Oral and Maxillofacial Surgery: You pay a $0 copay There is a $1,000 maximum plan benefit limit for comprehensive dental services **Benefits may be subject to exclusions and limitations per the American Dental Association (ADA) guidelines.**	There is no coinsurance, copayment, or deductible for covered services. You may be responsible for costs if a service is not covered or if you exceed your maximum allowance. Limitations and exclusions may apply. Note: This coverage is for Medicare Supplemental Dental Benefit. Some dental services are available through the Medi-Cal Dental Program. Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at dental.dhcs.ca.gov/ for more information.

Services that our plan pays for		What you must pay
		You may be eligible to receive additional dental services through the Medi-Cal Dental Program when you visit a Medi-Cal dental provider. See Section F2 for more information on benefits through the Medi-Cal Dental Program. *Prior Authorization may be required.*
	**Depression screening** We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	$0 There is no coinsurance, copayment, or deductible for an annual depression screening visit. *Prior Authorization may be required.* *Referral may be required.*
	**Diabetes screening** We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	**Diabetic self-management training, services, and supplies** We pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ◦ a blood glucose monitor ◦ blood glucose test strips ◦ lancet devices and lancets ◦ glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: ◦ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or** ◦ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.	$0 You pay $0 for this benefit. Supplies are covered when you have a prescription and fill it at a network retail pharmacy or through the Mail Service Pharmacy program. See “Vision care” in this chart for doctor’s services if you need an eye exam for diabetic retinopathy or a glaucoma screening. See “Podiatry services ” in this chart if you are diabetic and need to see a doctor for a foot exam. See “Medical nutrition therapy” in this chart if you are diabetic and need medical nutrition therapy services (MNT). *Prior Authorization may be required.* *Referral may be required.*
	Doula Services For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery.	$0

Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your *Member Handbook* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs, including electric wheelchairs • crutches • powered mattress systems • dry pressure pad for mattress • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.	You pay $0 for Medicare-covered DME and related supplies. *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	Emergency care Emergency care means services that are: • given by a provider trained to give emergency services, **and** • needed to treat a medical emergency. A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your health or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part. • In the case of a pregnant woman in active labor, when: ◦ There is not enough time to safely transfer you to another hospital before delivery. ◦ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Emergency care is only within the United States and its territories except under limited circumstances. Contact the plan for details. As an added benefit, we offer up to $100,000 of worldwide emergency coverage each calendar year for emergency transportation, urgent care, and emergency care. Refer to “Worldwide emergency/urgent coverage” in this chart if you need emergency ambulance transport outside the U.S.	$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.

Services that our plan pays for		What you must 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 does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	$0

Services that our plan pays for		What you must pay
	Fitness Benefit (Supplemental) **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1] . You have access to instructors who lead specially designed group exercise classes[2] . At participating locations nationwide[1] , you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers LIVETM classes, SilverSneakers On-DemandTM videos and our mobile app, SilverSneakers GOTM. Plus, you get access to GetSetUp[3] , with thousands of live online classes to ignite your interests in topics like cooking, technology and art. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-888-423-4632 (TTY: 711) Monday through Friday, 5 a.m. to 5 p.m. PT. **Always talk with your doctor before starting an exercise program.** • [1] Participating locations (“PL”) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. • [2] Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. • [3] GetSetUp is a third-party service provider and is not owned or operated by Tivity Health, Inc. (“Tivity”) or its affiliates. Users must have internet service to access GetSetUp service. Internet service charges are responsibility of user. Charges may apply for access to certain GetSetUp classes or functionality.	There is no coinsurance, copayment, or deductible for this benefit. Always talk to your doctor before starting or changing your exercise routine.
	Flex Card Flex Card funds are provided on a debit card that will be funded every month and/or quarter. Unused amounts in each month and/or quarter do not roll over to the next month and/or quarter. The funds in each benefit category will be on the same debit card but may only be used for the items/services contained in that category.	

Services that our plan pays for		What you must pay
	• **Over-the-counter (OTC) Items** OTC items are drugs and health related products that do not need a prescription. You will have an allowance for the purchase of plan approved OTC items. • **Over-the-counter (OTC) Hearing Aids** You can use your OTC allowance to purchase OTC Hearing Aids • **Herbal Catalog** You can use your OTC allowance to purchase health and wellness herbal catalog items.	Up to $175 every 3 months for OTC items, OTC hearing aids and herbal catalog items. You may be responsible for costs if you exceed your maximum monthly allowance. Limitations and exclusions may apply.
	• **Fitness Allowance** You will have an allowance to use for qualifying fitness expenses or fitness locations. You can find a catalog that lists approved items for OTC and health and wellness herbal items at www.centralhealthplan.com. You will need to activate your debit card before it can be used. For help with the Flex Card benefit, please call Member Services (phone numbers are printed on the back cover of this document).	Up to $20 every month for qualifying fitness expenses
	**Health and wellness education programs** We offer many programs that focus on certain health conditions. These include: • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; **and** Nursing Hotline	$0 *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. You are covered for 1 hearing exam every 2 years, and fitting/ evaluation for hearing aids 1 every 2 years under your Medi-Cal (Medicaid) benefit. Our plan covers an additional fitting/evaluation for hearing aids 1 every year. In addition to the Medicare-covered hearing services, you can get a routine hearing test once every calendar year. After the routine hearing test, you may be fitted for a hearing aid. If you are told you need hearing aids, you have a hearing aid allowance of $3000 every year for both ears combined. Fitting / evaluation for hearing aids can be done once every calendar year. If you are told you need hearing aids, you can get up to 2 pre-selected hearing aids from a plan-approved provider every year for both ears combined. 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	$0 *Prior Authorization may be required.* *Referral may be required.*
	Help with certain chronic conditions – Special Supplemental Benefits for the Chronically Ill (SSBCI) If you are diagnosed with an eligible chronic condition(s) and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill. In addition to having one of the qualifying chronic conditions listed under each benefit, you must also complete a Health Risk Assessment every year to qualify for one of the SSBCI benefits. We will review your eligibility annually.	

Services that our plan pays for		What you must pay
	Scales A scale is provided to qualifying members with kidney disease or chronic heart failure who do not meet Medicare guidelines for coverage.	You pay a $0 copay for plan approved scales. *Prior Authorization may be required*.
	Healthy Food Allowance To qualify for the healthy food allowance, you must have one or more of the following conditions. • Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder) • Chronic heart failure • Dementia • Diabetes • Chronic lung disorders You receive a debit card that will allow you to purchase healthy foods at participating retailers by swiping your card at the checkout line. You receive your card in the mail at the time you are eligible for this benefit and use it during the plan year. Cash withdrawal, tobacco, firearms and alcohol are prohibited. For help with this benefit, please call Member Services (phone numbers are printed on the back cover of this document).	Up to $25 per month to buy healthy foods at plan-approved grocery stores. This amount does not roll over and expires are the end of each month. *Prior Authorization may be required.*
	Non-Medical Transportation To qualify for the non-medical transportation, you must have one or more of the following conditions. • Cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder) • Chronic heart failure • Dementia • Diabetes • Chronic lung disorders You may use up to half of your one-way trips covered through your Transportation (Additional Routine) benefit (up to 50 miles) to travel to and from grocery stores, fitness clubs, and senior centers. These one-way trips count towards your 24 one-way trips limit for Transportation (Additional Routine). Please refer below to Transportation (Additional Routine) for more information.	You pay a $0 copay for plan approved nonmedical transportation *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	**HIV screening** We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy. We also pay for additional HIV screening(s) when recommended by your provider.	$0 There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening *Prior Authorization may be required.* *Referral may be required*
	Home-delivered meals To qualify for this benefit, you must have a diagnosis of diabetes, chronic heart failure, cardiovascular disorders (limited to cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic disorder), dementia or chronic lung disorders. • You get ready-to-heat-and-eat frozen meals delivered to your home. • You'll get 14 meals delivered each month. • You can use this meal benefit each month for 12 months. • You get access to the Personal Concierge for the entire calendar year. To get started: Call Member Services at the numbers listed at the bottom of this page.	$0 *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	$0 *Prior Authorization may be required.* *Referral may be required*
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	$0 *Prior Authorization may be required.* *Referral may be required*

Services that our plan pays for		What you must 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. 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 **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section F** of this chapter for more information. **For services covered by our plan but not covered by Medicare Part A or 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. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Member Handbook.* **Note:** If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section below for more information. **Note:** If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Central Health Plan Medi-Medi Plan I (HMO D-SNP). Hospice consultations are included as part of inpatient hospital care. Physician service costsharing may apply for outpatient consultations.

Services that our plan pays for		What you must 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 are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • human papillomavirus (HPV) vaccine • other vaccines if you are 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 your *Member Handbook* to learn more. We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP)	$0 There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines. *Prior Authorization may be required.* *Referral may be required*
	In-home support services Services are eligible to members following discharge from the hospital or skilled nursing facility or through case management referral. Benefit includes companionship, assistance with activities of daily living, medication pick-ups, and shopping for groceries or other necessities. Services must be accessed using the plan's contracted vendor. There is a limit of up to 20 hours per calendar year. Contact Member Services for more information at the numbers listed at the bottom of this page. In-home support services are separate from Home health agency care. Refer to the "Home health agency care" in this chart for more information. Members with Medi-Cal may be eligible for a different benefit called In-Home Supportive Services (IHSS) through the Medi-Cal program. The IHSS benefit through Medi-Cal is not administered by Central Health Medi-Medi Plan I (HMO D-SNP) and is separate from this coverage.	There is no coinsurance, copayment, or deductible in In-Home Support Services. *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	In-home meal program If you meet certain criteria, you may qualify to receive pre-cooked meals delivered to your home. You may qualify for this benefit immediately following surgery or hospital discharge, or if you are ordered to isolate at home for 14 days by a healthcare provider due to a COVID-19 diagnosis or exposure. This benefit is limited to 2 meals per day, up to 14 days (28 meals total). This benefit is available up to 4 times per year.	$0 *Prior Authorization may be required*.
	In-home safety assessment and home bathroom safety devices and modifications If you do not qualify for an in-home safety assessment under Original Medicare's home health benefit, you receive an assessment of your fall risk by a qualified health professional to determine whether you qualify for home bathroom safety devices or modifications. Qualifying members receive a maximum of $3,000 each year that includes the cost of purchasing and installing allowed safety devices, including: • Grab bars secured to bathtub walls • Non-slip or non-skid bathmats • Tub benches so you can slide into the tub without stepping into the tub • Shower chairs • A handheld shower head that allows you to bathe while seated • Toilet chairs • A raised toilet seat Qualifying members can use their benefit for allowed home modifications contingent upon an in-home assessment. Home modifications include: • Grab bars	There is no coinsurance, copayment, or deductible for In-Home Safety Assessment. You receive up to a $3,000 allowance for the purchase and installation of Home and Bathroom Safety Devices and Modifications every year. This amount expires at the end of the calendar year. You are responsible for any amounts beyond the allowance. *Prior Authorization may be required*.

Services that our plan pays for		What you must 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. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. Central Health Medi-Medi Plan I (HMO D-SNP) will provide reimbursement for lodging and meals while in the distant location for transplant related medical care, with a daily maximum of up to $150 per day. In addition, mileage reimbursement can be requested at the amount equivalent to the standard mileage rates for taxpayers as described by the Internal Revenue Service (IRS) that is adjusted and notice published publicly. The maximum amount payable for all travel, lodging, meals, and mileage reimbursement is five-thousand dollars ($5,000) per transplant in accordance with plan guidelines.	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	• blood, including storage and administration, coverage begins with the first three pints of blood that you need • physician services **This benefit is continued on the next page**	
	Inpatient hospital care (continued) **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 are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available at es.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. You can call these numbers for free, 24 hours a day, 7 days a week.	$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. *Prior Authorization may be required.* *Referral may be required.*
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency. ◦ The 190-day limit does **not** apply to inpatient mental health services provided in a psychiatric unit of a general hospital • If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD).	$0 There is no coinsurance, copayment, or deductible for this benefit. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary. However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor services • diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • 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 There is no coinsurance, copayment, or deductible for this benefit. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to “Medicare Part B prescription drugs” in this chart.	$0 Medicare covers up to 6 sessions per lifetime. *Prior Authorization may be required*.
	**Lung cancer screening** Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visits. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	**Medical nutrition therapy** This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's 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 There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services. *Prior Authorization may be required.* *Referral may be required.*
	**Medicare Diabetes Prevention Program (MDPP)** Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	$0 There is no coinsurance, copayment, or deductible for the (MDPP) benefit. *Prior Authorization may be required.* *Referral may be required.*
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • 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) • clotting factors you give yourself by injection if you have hemophilia **This benefit is continued on the next page**	$0 Part B drugs may be subject to step therapy. *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued) • 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 does not cover them • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • 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 if the same drug is available in injectable form and the Part B ESRD benefit covers it • calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics • erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (Procrit®) • IV immune globulin for the home treatment of primary immune deficiency diseases • parenteral and enteral nutrition (IV and tube feeding) **This benefit is continued on the next page**	

Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs (continued) The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: www.centralhealthplan.com We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D prescription drug benefit. **Chapter 5** of your *Member Handbook* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Member Handbook* explains what you pay for your outpatient prescription drugs through our plan.	

Services that our plan pays for		What you must pay
	Nursing facility care A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • 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.	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Nursing Hotline 24/7 Nurse Advice Line staffed by registered nurses. Nurses will triage conditions and assist members in determining next steps for medical concerns. When applicable, nurses will talk with qualified providers as needed.	$0 *Prior Authorization may be required.*
	**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 There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. *Prior Authorization may be required.* *Referral may be required.*
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use disorder counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	*$0* You pay $0 for Medicare-covered outpatient opioid treatment program services. *Prior Authorization may be required.* *Referral may be required.*
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • other outpatient diagnostic tests	$0 You pay $0 for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ◦ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient." ◦ Sometimes you can be in the hospital overnight and still be "outpatient." ◦ You can get more information about being inpatient or outpatient in this fact sheet: es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf. • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws We pay for the following services, and maybe other services not listed here: • clinic services • day treatment • psychosocial rehab services • partial hospitalization or intensive outpatient programs • individual and group mental health evaluation and treatment • psychological testing when clinically indicated to evaluate a mental health outcome • outpatient services for the purposes of monitoring drug therapy • outpatient laboratory, drugs, supplies and supplements • psychiatric consultation Your Medi-Cal benefits include specialty mental health services for individuals who qualify. These specialty mental health services are covered outside of our plan. Please see Chapter 3, Section F.1 for more information on these services and how to access them.	You pay $0 per event for non-physician outpatient mental health care and psychiatric services including monitoring drug therapy and individual or group therapy visits. *Prior Authorization may be required.* *Referral may be required.*
	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.	You pay $0 for each medically-necessary outpatient physical therapy (PT), occupational therapy (OT), and/ or speech-language (SP) visit. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must 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 *Prior Authorization may be required.* *Referral may be required.*
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	You pay $0 for each covered outpatient surgery event including, but not limited to, hospital or other facility charges and physician or surgical charges. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must 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 is **not** hospice, therefore you do not 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 are over the age of 21. If you are getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.	$0
	Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's, 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 is more intense than the care received in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	$0 You must meet certain requirements to qualify for coverage and your doctor must certify that you would otherwise need inpatient treatment This treatment is given during the day in a hospital outpatient department or community mental health center and doesn't require an overnight stay. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Personal Emergency Response System (PERS) You will have access to an advanced medical alert system. Your PERS device helps independent adults balance freedom and safety while connecting you to everyone in your care circle – including doctors, nurses, family, and friends.	You pay a $0 copay for a mobile PERS device with GPS and fall detection, 24/ 7/365 monitoring. *Prior Authorization may be required.*
	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 • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider ***or*** specialist, if your doctor orders them to find out whether you need treatment • Certain telehealth services, including *additional telehealth benefits*. ◦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • Telehealth benefits include but are not limited to two-way video exchange and remote monitoring devices. Contact your provider for details. Use of a telehealth benefit requires an internet connection • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder **This benefit is continued on the next page**	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits (continued) • telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ you have an in-person visit within 6 months prior to your first telehealth visit ◦ you have an in-person visit every 12 months while receiving these telehealth services ◦ exceptions can be made to the above for certain circumstances • telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if** ◦ you're not a new patient **and** ◦ the check-in isn't related to an office visit in the past 7 days **and** ◦ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**: ◦ you're not a new patient and ◦ the evaluation isn't related to an office visit in the past 7 days **and** ◦ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery • Non-routine dental care. Covered services are limited to: ◦ surgery of the jaw or related structures ◦ setting fractures of the jaw or facial bones ◦ pulling teeth before radiation treatments of neoplastic cancer ◦ services that would be covered when provided by a physician	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must 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	$0 There is no coinsurance, copayment, or deductible for these services. *Prior Authorization may be required.* *Referral may be required.*
	**Prostate cancer screening exams** For men age 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	$0 There is no coinsurance, copayment, or deductible for an annual PSA test. *Prior Authorization may be required.* *Referral may be required.*
	Prosthetic and orthotic devices and related supplies Prosthetic devices replace all or part of a body part or function. These include but are not 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 of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect • incontinence cream and diapers We pay for some supplies related to prosthetic 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.	You pay $0 for each Medicare-covered prosthetic or orthotic device, including replacement or repairs of such devices, and related supplies. *Prior Authorization may be required.*

Services that our plan pays for		What you must 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.	$0 You pay $0 for each Medicare-covered pulmonary rehabilitative visit *Prior Authorization may be required.* *Referral may be required.*
	**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 There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefits. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration, coverage begins with the first three pints of blood that you need • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing 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	$0 *Prior Authorization may be required.* *Referral may be required.*
	Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.	$0 There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	$0 You pay $0 for Medicare-covered Supervised Exercise Therapy (SET) visits. *Prior Authorization may be required.* *Referral may be required.*
	Transportation (Additional Routine) You receive 24 one-way non-emergency transportation trips via contracted transportation providers to plan-approved locations to receive health care services from network providers. There is a 50-mile limit per trip. Available modes of transportation include taxi, van, medical transport, or rideshare services. Transportation must be scheduled at least 2 business days in advance of the scheduled appointment to ensure availability. Please contact Member Services (phone numbers are printed on the back cover of this document) to schedule an appointment. Cancellations must be received by Member Services at least 24 hours prior to the pickup time to avoid counting against your transportation benefit.	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must 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 is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Emergency care is only within the United States and its territories except under limited circumstances. Contact the plan for details. As an added benefit, we offer up to $100,000 of worldwide emergency coverage each calendar year for emergency transportation, urgent care, emergency care, and post-stabilization care.	You pay $0 for each Medicare-covered urgently needed care visit. Your cost-share is the same for network or out-of-network urgent care services.

Services that our plan pays for		What you must pay
	**Vision care** We pay for the following services: • one routine eye exam every year **and** • up to $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses every two years We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are age 50 and over • Hispanic Americans who are 65 or over We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.	$0 *Prior Authorization may be required.* *Referral may be required.*

Services that our plan pays for		What you must pay
	Vision care (Supplemental) We have partnered with EyeMed to give you more value for your routine vision needs. Coverage includes: • One routine eye exam every calendar year • Up to a $300 eyewear allowance every calendar year You can use your eyewear allowance to purchase: • Contact lenses (in lieu of eyeglasses) • Eyeglasses (lenses and frames) • Eyeglass lenses and / or frames • Upgrades (such as, tinted, U-V, polarized or photochromatic lenses). *If you choose contact lenses, your eyewear allowance can also be used to pay down all or a portion of your contact lens fitting fee. You are responsible for paying for any corrective eyewear over the limit of the plan's eyewear allowance. You pay $0 for up to one routine eye exam (and refraction) for eyeglasses every calendar year. You have an eyewear allowance of $300 every calendar year. For your routine eye exam, to find an in-network routine preventive vision provider close to you, you can: Search online using our supplemental vision provider online search tool at www.centralhealthplan.com/Materials/EyeCare. Supplemental benefits are offered by the plan to help with items or services that are generally not covered by Medicare. All benefits must be used in the plan year and are only available if you are enrolled at the time services are rendered. **You may be able to access additional optometry, eye appliance, and low vision aids services through your Medi-Cal benefits.**	There is no coinsurance, copayment, or deductible for this benefit. *Prior Authorization may be required.*

Services that our plan pays for		What you must pay
	**"Welcome to Medicare" preventive visit** We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0 There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. *Prior Authorization may be required.*
	Worldwide Emergency Coverage The plan covers emergency care received worldwide (Worldwide includes emergency care received outside of the Unites States and its' territories). Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States and it's territories. If you have an emergency outside of the U.S. and its territories, you will be responsible for paying the services rendered upfront. You must submit a discharge summary or equivalent medical documentation and proof of payment in English and U.S. dollars for reimbursement from Central Health Medi-Medi Plan I (HMOD-SNP). We will review the documentation for medical necessity and appropriateness before reimbursement is made. We may not reimburse you for all out-of-pocket expenses. If clinical notes are not in English, you will need to provide a certified translation. If payment invoice is not in U.S. dollars, reimbursement will be calculated using the exchange rate at the time the check is processed. Payments are tendered in U.S. dollars only. Monetary exchange rate fees, translations costs, postage, return travel to the U.S., and other non-medical fees are not reimbursable.	You pay a $0 copay per trip for worldwide emergency services. You will be responsible to pay for the services upfront and then submit a reimbursement request. There is a $100,000 per year annual maximum for worldwide services, including worldwide emergency services, worldwide urgently needed, and worldwide emergency transportation services combined.

Services that our plan pays for		What you must pay
	Worldwide Emergency Transportation Coverage Coverage is provided for emergency transportation services received worldwide. (Worldwide refers to emergency care received outside of the United States and its territories). Emergency transportation must be provided by a licensed emergency transportation vehicle. If you have an emergency outside of the U.S. and its territories, you will be responsible for paying the services rendered upfront. You must submit a discharge summary or equivalent medical documentation and proof of payment in English and U.S. dollars for reimbursement from Central Health Medi-Medi Plan I (HMO D-SNP). We will review the documentation for medical necessity and appropriateness before reimbursement is made. We may not reimburse you for all out of pocket expenses. If clinical notes are not in English, you will need to provide a certified translation. If payment invoice is not in U.S. dollars, reimbursement will be calculated using the exchange rate at the time the check is processed. Payments are tendered in U.S. dollars only. Monetary exchange rate fees, translations costs, postage, return travel to the U.S., and other non medical fees are not reimbursable.	You pay a $0 copay per trip for worldwide emergency transportation services. There is a $100,000 per year annual maximum for worldwide services, including worldwide emergency services, worldwide urgently needed, and worldwide emergency transportation services combined.
	Worldwide Urgently Needed Services Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States and it's territories. If you have an emergency outside of the U.S. and its territories, you will be responsible for paying the services rendered upfront. You must submit a discharge summary or equivalent medical documentation and proof of payment in English and U.S. dollars for reimbursement from Central Health Medi-Medi Plan I (HMO D-SNP). We will review the documentation for medical necessity and appropriateness before reimbursement is made. We may not reimburse you for all out-of-pocket expenses. If clinical notes are not in English, you will need to provide a certified translation. If payment invoice is not in U.S. dollars, reimbursement will be calculated using the exchange rate at the time the check is processed. Payments are tendered in U.S. dollars only. Monetary exchange rate fees, translations costs, postage, return travel to the U.S., and other non-medical fees are not reimbursable.	You pay a $0 copay per visit for worldwide urgently needed services. You will be responsible to pay for the services upfront and then submit a reimbursement request. There is a $100,000 per year annual maximum for worldwide services, including worldwide emergency, worldwide urgently needed, and worldwide emergency transportation services combined.

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 do not replace benefits that you already receive under Medi-Cal.

Housing Transition Navigation Services: Assists members experiencing homelessness with obtaining housing by providing support with items such as housing applications, benefits advocacy, securing available resources, and providing help with landlords upon move-in.
Eligibility:

- Members prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System (CES) or similar system; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving Enhanced Care Management (ECM), or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Housing Deposits: Assists members experiencing homelessness with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that does not constitute room and board. These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the member is unable to meet such expense. Members must be receiving or be referred for Housing Transition Navigation Services CS.

Eligibility:

- Members who received Housing Transition Navigation Services CS; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES or similar system; or
- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder.
- Restriction/Limitation: Available once in a member's lifetime. Housing Deposits can only be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt.

Housing Tenancy and Sustaining Services: Provides tenancy and sustaining services to maintain safe and stable residency once housing is secured for members who had been experiencing homelessness and are now newly housed.

Eligibility:

- Members who received Housing Transition/Navigation Services CS; or
- Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless CES or similar system; or
- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.
- Restriction/Limitation: Housing Tenancy and Sustaining Services are only available for a single duration in the individual's lifetime and can be approved one additional time. Referrer must provide documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt.

Short-Term Post-Hospitalization Housing: Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/ substance use disorder recovery immediately after exiting an inpatient hospital, residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.

Eligibility:

- Members who have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, rehospitalization, or institutional readmission; and
- Members who are exiting recuperative care; or
- Members who are exiting an inpatient hospital stay (acute, psychiatric, or Chemical Dependency and Recovery hospital), residential substance use disorder treatment/recovery facility, residential mental health treatment facility, correctional facility, or nursing facility AND who meet one of the following three (3) criteria:

- Members who meet the HUD definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or **Recuperative Care (Medical Respite):** Members needing short-term residential care who no longer require hospitalization but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. Clinical information must be provided.

Eligibility:

- Members who are at risk of hospitalization or are post-hospitalization and live alone with no formal support; or face housing insecurity or have housing that would jeopardize their health and safety without modification; or
- Members who meet the Housing and Urban Development (HUD) definition of homeless and who are receiving ECM, or who have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or requiring residential services as a result of a substance use disorder; or
- Members who meet the HUD definition of being at risk of homelessness; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.
- Restriction/Limitation: Recuperative Care is not more than ninety (90) days in continuous duration. The ninety (90) day recuperative care period may start over if the member is re-hospitalized with a different diagnosis during and/or after the initial ninety (90) day authorization, provided that recuperative care criteria is met.

Respite Services: Provided to caregivers when it is useful and necessary to maintain a member in their own home and to preempt caregiver burnout to avoid institutional services. The services are provided on a short-term basis because of the absence or need for relief for the caregiver and are non-medical in nature. This service is rest for the caregiver only and only to avoid Long-Term Care placements.

- Members who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations; or
- Members at risk of experiencing homelessness and have one or more serious chronic conditions; have a serious mental illness; are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a Serious Emotional Disturbance (children and adolescents); are receiving ECM; or are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

- Restriction/Limitation: Short-Term Post-Hospitalization Housing is available once in a member's lifetime and cannot exceed six (6) months (but may be authorized for a shorter period based on member's needs).

Eligibility:

- Members who live in the community and are compromised in their Activities of Daily Living (ADLs) requiring dependency on a qualified caregiver, and the qualified caregiver, who provides most of the member's support, requires caregiver relief to avoid institutional placement for the member; or
- Member is a child who previously received Respite Services under the Pediatrics Palliative Care Waiver.
- Restriction/Limitation: These services, in combination with any direct care services being received, may not exceed 24 hours per day of care. Respite Services are maxed at 336 hours per calendar year.

Day Habilitation Programs: Provided in a member's home or an out-of-home, non-facility setting to assist members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the member's natural environment.

Eligibility:

- Members who are experiencing homelessness; or
- Members who exited homelessness and entered housing in the last 24 months; or
- Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities: Assists members to live in the community and/or avoid institutionalization when possible. Facilitates nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for members with imminent need for nursing level of care (LOC). Members have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. California Community Transitions (CCT) must be explored and utilized prior to this Community Support.

Eligibility:

Nursing Facility Transition:

Has resided 60+ days in a nursing facility; and willing to live in an assisted living setting as an alternative to a nursing facility; and able to reside safely in an assisted living facility with appropriate and cost-effective supports.

Nursing Facility Diversion:

Interested in remaining in the community; and willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an assisted living facility.

Restrictions/Limitations: Members are directly responsible for paying their own living expenses.

Community Transition Services/Nursing Facility Transition to a Home: Assists members who have been living in a nursing facility to live in the community and avoid further institutionalization by supporting members with becoming housed in a private residence and covering non-recurring setup expenses.

Eligibility:

- Members currently receiving medically necessary nursing facility level of care (LOC) services and in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and
  - Has lived 60+ days in a nursing home and/or Medical Respite setting; and
  - Is interested in moving back to the community; and
  - Is able to reside safely in the community with appropriate and cost-effective support and services.
- Restriction/Limitation: Community Transition Services/Nursing Facility Transition to a Home is available once in an individual's lifetime with a lifetime maximum of $7,500. Community Transition Services/Nursing Facility Transition to a Home can only be approved one additional time. Referrer must provide documentation that the member was compelled to move from a provider- operated living arrangement to a living arrangement in a private residence through circumstances beyond their control.

Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

Personal Care and Homemaker Services: Provides care for members who need assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Eligibility:

- Members at risk for hospitalization or institutionalization in a nursing facility or with functional deficits and no other adequate support system with:
  - Needs above and beyond any approved county In-Home Supportive Services (IHSS) hours when additional hours are required (pending reassessment); or
  - Initially referred to IHSS and during the IHSS waiting period to be approved and hire a caregiver (Member must be already referred to In-Home Supportive Services); or
  - Members not eligible to receive In-Home Supportive Services and need help to avoid a short-term stay in a skilled nursing facility which cannot exceed 60 days.

Environmental Accessibility Adaptations (Home Modifications): Physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the member, or enable the member to function with greater independence in the home: without with the member would require institutionalization.

Eligibility:

Members at risk for institutionalization in a nursing facility.

Restrictions/Limitations: EAAs are payable up to a total lifetime maximum of $7500. The only exceptions to the $7500 total maximum are if the member's place of residence changes or if the member's condition has changed so significantly those additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

Medically Supportive Food/Meals/Medically Tailored Meals: Provides meals for members recently discharged from a hospital or skilled nursing facility or to meet the unique dietary needs of members with chronic conditions.

Eligibility:

- Members discharged from the hospital or a skilled nursing facility or at a high risk of hospitalization or nursing home placement who are referred and meet criteria will receive up to two (2) meals per day, and/or medically supportive food for up to four (4) weeks per hospitalization at a maximum of twelve (12) weeks in a calendar year.
- Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

Sobering Centers: Provides alternative destinations for members 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. The service covered is for a duration of less than 24 hours.

Eligibility:

- Members aged 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, and free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Asthma Remediation: Assists members by identifying, coordinating, securing, or funding services and modifications necessary to a home environment to ensure the health, welfare, and safety of the individual or to enable the individual to function in the home without acute asthma episodes, which could result in the need for emergency services and hospitalization. The referral must be signed by a licensed health care professional.

Eligibility:

- Members with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two Primary Care Physician (PCP) or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the services will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.
- Restriction/Limitation: Asthma Mitigation Project funding must be explored and utilized prior to the CS. Asthma Remediation are available once in an individual's lifetime with a lifetime maximum of $7,500. Asthma Remediation can only be approved one additional time. Referrer must provide documentation describing the significant changes to condition that additional modifications are necessary to ensure the health, welfare, and safety of the member, or are necessary to enable the member to function with greater independence in the home and avoid institutionalization or hospitalization.

All Community Supports, except for Sobering Centers, require prior approval by Central Health Plan.

If you need help or would like to find out which Community Supports may be available for you, call 1-866-314-2427 (TTY 711) or call your health care provider.

F. Benefits covered outside of our plan

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

F1. California Community Transitions (CCT)

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

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

For CCT transition coordination services

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

For services not related to your CCT transition

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

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

No change in drug coverage benefit

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

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

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 is not limited to, services such as:

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

For more information regarding dental benefits available in Medi-Cal Dental, or if you need help finding a dentist who accepts Medi-Cal, contact the 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 8:00

a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at smilecalifornia.org/ for more information.

In Sacramento and Los Angeles counties, you may get Medi-Cal dental benefits through a Dental Managed Care (DMC) plan. If you want more information about Medi-Cal dental plans or want to make changes, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free. DMC contacts are also available here: www.dhcs.ca.gov/services/Pages/ManagedCarePlanDirectory.aspx.

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

F3. Hospice care

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

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

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

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

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

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

For drugs that may be covered by our plan's Medicare Part D benefit

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

Note: If you 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 above for more information.

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

F4. In-Home Supportive Services (IHSS)

- The IHSS Program will help pay 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.

- 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. For information on county-specific social services agency information, visit https://www.cdss.ca.gov/inforesources/county-ihss-offices.

F5. 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.
- Your care coordinator can help you apply for the ALW. For information on participating ALW care coordination agencies, visit dhcs.ca.gov/services/ltc/Documents/Care-Coordination-Agencies.pdf.

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. For information on local HCBA agencies, visit dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx.

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. For a directory of MCWP agencies, visit 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 are not 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. For information on MSSP providers, visit https://aging.ca.gov/Programs_and_Services/Multipurpose_Senior_Services_Program/.

F6. County Behavioral Health Services Provided Outside Our Plan (Mental Health and Substance Use Disorder Services)

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan does not provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through county behavioral health agencies.

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by your county MHP include:

- mental health services
- medication support services
- day treatment intensive
- day rehabilitation
- crisis intervention
- crisis stabilization
- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management
- peer support services
- therapeutic behavioral services
- therapeutic foster care
- intensive care coordination
- intensive home-based services

Drug Medi-Cal Organized Delivery System services are available to you through your county behavioral health agency if you meet criteria to receive these services. Drug Medi-Cal services provided by your 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

Drug Medi-Cal Organized Delivery System 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

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 do not pay for these benefits. Medicare and Medi-Cal do not 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 do not pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Member Handbook*.

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

- services considered not “reasonable and medically necessary,” according 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 your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- meals delivered to your home

- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we 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 will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Medi-Cal. **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your Member Handbook.

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to **Chapter 5**, Section F "If you are in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

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

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

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

You generally must use a network pharmacy to fill your prescription 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 is not on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.
- Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

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 before we will cover it. Refer to **Section C** in this chapter.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

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

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

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 prescription drug.

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

If you don't have your Member ID Card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

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

If you can't pay for the drug, contact Member Services right away. We will do everything we can to help.

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

A3. What to do if you change your network pharmacy

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

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

A4. What to do if your pharmacy leaves the network

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

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

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.

- 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 is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Care Provider (IHCP) and Urban Indian Organization (UIO) Pharmacies Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs **not** available through our plan's mail-order service are marked with "NM" in our *Drug List*.

Our plan's mail-order service allows you to order at least a 31-day supply of the drug and no more than a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please contact Member Services.

Usually, a mail-order prescription arrives within 14 days. If there is an urgent need or this timing is delayed, please call Member Services (phone numbers for Member Services are printed on the back cover of this booklet) for help in receiving a temporary supply of your prescription.

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 it is shipped.
   - Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills, contact your pharmacy 14 days before your current prescription will run out to make sure your next order is shipped to you in time. If you have difficulty and need assistance, please contact your care coordinator at 1-866-314-2427, TTY: 711.

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

A7. Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 31-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 your care coordinator or Member Services for more information.

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. In these cases, check with your care coordinator or Member Services first to find out if there's a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

- If the prescription is related to urgently needed care
- If these prescriptions are related to care for a medical emergency
- Coverage will be limited to a 31-day supply unless the prescription is written for less

In these cases, check with Member Services or your care coordinator first to find out if there's a network pharmacy nearby.

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.

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

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

B. Our plan's *Drug List*

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

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

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

B1. Drugs on our *Drug List*

Our *Drug List* includes drugs covered under Medicare Part D.

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

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is 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 that are 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 Member Services.

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.centralhealthplan.com. The *Drug List* on our website is always the most current one.
- Call your care coordinator or Member Services to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information
- Use our "Real Time Benefit Tool" at www.caremark.com or call your care coordinator or Member Services. With this tool you can search for drugs on the *Drug List* to get an estimate of what you will pay and if there are alternative drugs on the *Drug List* that could treat the same condition.

B3. Drugs not on our *Drug List*

We don't cover all prescription drugs. Some drugs are not on our *Drug List* because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our *Drug List*.

Our plan does not 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 your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Medicare Part D) cannot 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 prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the 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 cannot 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.

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

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

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

C. Limits on some drugs

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

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

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

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

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

   - We usually do not pay for the brand name drug when there is an available generic version.

   However, if your provider told us the medical reason that the generic drug won't work for you ***or*** wrote "No substitutions" on your prescription for a brand name drug ***or*** told us the medical reason that the generic drug or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.

2. **Getting plan approval in advance**

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

3. **Trying a different drug first**

   In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

   If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Member Services or check our website at www.centralhealthplan.com. 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 the *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 is not on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

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

1. The drug you've been taking:
   - is no longer on our *Drug List* **or**
   - was never on our *Drug List* **or**
   - is now limited in some way.
2. You must be in one of these situations:
   - You were in our plan last year.
     - We cover a temporary supply of your drug **during the first 100 days of the calendar year**.
     - This temporary supply is for up to (31) supply limit days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of (31) days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
   - You are new to our plan.
     - We cover a temporary supply of your drug **during the first 100 days of your membership in our plan**.
     - This temporary supply is for up to 31 days.
     - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 31 days of medication. You must fill the prescription at a network pharmacy.
     - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You have been in our plan for more than 100 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.
  - Please note that our transition policy applies only to those drugs that are “Part D” and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access.

D2. Asking for a temporary supply

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

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

- **Change to another drug.**

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

  OR

- **Ask for an exception.**

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our *Drug List* or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

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).

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

If you need help asking for an exception, contact Member Services or your care coordinator.

E. Coverage changes for your drugs

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

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

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

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

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

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

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

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

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

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

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

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

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

A drug is taken off the market. If the FDA says a drug you are taking is not safe or effective or the drug’s manufacturer takes a drug off the market, we may immediately take it off our *Drug List*. If you are taking the drug, we will send you a notice after we make the change.

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 31 day supply of the drug after you ask for a refill.

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

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

Changes to the *Drug List* that do not affect you during the current plan year

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

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

If any of these changes happen for a drug you are 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 will not tell you above these types of changes directly during the current year. You will 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 are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing 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 prescription drugs through the facility's pharmacy if it is part of our network.

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

F3. In a Medicare-certified hospice program

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

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.

- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

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

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another 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
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

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 will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, 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 do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services or your care coordinator.

G3. Drug management program for safe use of opioid medications

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

If you use opioid medications that you get from several 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 is not safe, we may limit how you can get those medications. Limitations may include:

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

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will 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 will 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. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

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

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

Introduction

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

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

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

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

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

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

- Our *List of Covered Drugs.*
  - We call this the "*Drug List*." It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at www.centralhealthplan.com.
  - Most of the prescription drugs you get from a pharmacy are covered by Central Health Medi-Medi Plan I (HMO D-SNP). Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx."
- **Chapter 5** of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
  - 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 provided in "real time," meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your care coordinator or Member Services 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 your Member Handbook more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)

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

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by "Extra Help" from Medicare, employer or union health plans, TRICARE, 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 the plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not 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. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information.** This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

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

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.**

   Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

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

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

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

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (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 is 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?

For more information, you can call Central Health Medi-Medi Plan I (HMO D-SNP) Member Services or read the Central Health Medi-Medi Plan I (HMO D-SNP) *Member Handbook*.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Central Health Medi-Medi Plan I (HMO D-SNP) Member Services. You can also find answers to many questions on our website: www.centralhealthplan.com.

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 Central Health Medi-Medi Plan I (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you suspect that a provider who gets Medi-Cal has committed fraud, waste, or abuse, it is your right to report it by calling the confidential toll-free number 1-800-822-6222. Other methods of reporting Medi-Cal fraud may be found at: www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They are an important record of your drug expenses.

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

With our plan, you pay nothing for covered drugs as long as you follow our rules. Refer to Chapter 9 of the *Member Handbook* to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to Chapter 5 of your *Member Handbook* and our *Provider and Pharmacy Directory*.

C1. 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 (100) day supply. There is no cost to you for a long-term supply.

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

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

D. Vaccinations

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 the plan’s *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan’s *List of Covered Drugs (Formulary)* or contact Member Services for coverage and cost sharing details about specific vaccines.

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

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

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

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

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

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

Introduction

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

Table of Contents

A. Asking us to pay for your services or drugs

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

We do not allow Central Health Medi-Medi Plan I (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, call Member Services at the numbers listed at the bottom of this page.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
  - If you paid for services covered by Medicare, we will 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 are responsible for paying. We will not reimburse you for a service that is not covered by Central Health Medi-Medi Plan I (HMO D-SNP).
  - You received the covered service after you became an eligible Central Health Medi-Medi Plan I (HMO D-SNP) member.
  - You ask to be paid back within one year from the date you received the covered service.
  - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
  - You received the covered service from a Medi-Cal enrolled provider in Central Health Medi-Medi Plan I (HMO D-SNP) ‘s network. You do not 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.
- Central Health Medi-Medi Plan I (HMO D-SNP) will tell you if they will 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, Central Health Medi-Medi Plan I (HMO D-SNP) will pay you back for the full amount you paid. We will reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but is not in our network and refuses to pay you back, Central Health Medi-Medi Plan I (HMO D-SNP) will pay you back, but only up to the amount that FFS Medi-Cal would pay. Central Health Medi-Medi Plan I (HMO D-SNP) will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you do not meet one of the above conditions, we will not pay you back.
- We will not pay you back if:
  - You asked for and received services that are not covered by Medi-Cal, such as cosmetic services.
  - The service is not a covered service for Central Health Medi-Medi Plan I (HMO D-SNP).

- You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services or your care coordinator if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

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

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

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you already paid for the Medicare service, we will 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 Member Services** or your care coordinator at the number at the bottom of this page **if you get any bills**.

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

3. **If you are 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 get a prescription filled**

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

   - In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
   - Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.
   - 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 would 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 your *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 your *Member Handbook*).
   - Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug. 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 your *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 can ask your care coordinator for help. You must send your information to us within 12 months of the date you received the service, item, or drug.

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

For Medical Services:

Attn: Medicare Member Services 200 Oceangate, Suite 100, Long Beach, CA 90802

For Part D (Rx) Services:

Molina Healthcare Attn: Pharmacy Department 7050 Union Park Center, Suite 200, Midvale, UT 84047

You must submit your claim to us within 12 months of the date you got the service, item, or drug.

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 will 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 will pay for it. If you already paid for the service or drug, we will 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 obtained 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 will pay the provider directly.

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

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

- If we decide not to pay for the service or drug, we will 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**.

D. Appeals

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

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

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

Chapter 8: Your rights and responsibilities

Introduction

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

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

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, in braille, in large print, or other alternate formats, etc). We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call your care coordinator or Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Tagalog, and Vietnamese and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services or write to:
  Central Health Medi-Medi Plan I (HMO D-SNP), Attn: Medicare Member Services 200 Oceangate, Suite 100, Long Beach, CA 90802
  - To make a standing request to get materials in a language other than English or in an alternate format now and in the future, please contact Member Services at 1-866-314-2427, TTY: 711, 8 a.m. – 8 p.m. PST.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.
- U.S Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

Spanish

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

- Para obtener información de una manera que pueda entender, llame a su coordinador de atención o a Servicios para Miembros. Nuestro plan tiene servicios de intérprete gratuitos disponibles para responder preguntas en diferentes idiomas.
  - Nuestro plan también puede proporcionarle materiales en idiomas distintos del inglés, incluyendo español, árabe, armenio, camboyano, chino, farsi, hmong, coreano, lao, ruso, tagalo y vietnamita, y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Miembros o escriba a Molina Medicare Complete Care Plus (855) 665-4627 TTY: 711 7 días a la semana, de 8:00 a.m. a 8:00 p.m., hora local. Para Servicios Médicos: 200 Oceangate, Suite 100 Long Beach, CA 90802

- Para hacer una solicitud permanente de recibir materiales en un idioma distinto del inglés o en un formato alternativo ahora y en el futuro, comuníquese con Servicios para Miembros al (855) 665-4627, TTY: 711 7 días a la semana, de 8:00 a.m. a 8:00 p.m., hora local. Si tiene problemas para obtener información de nuestro plan debido a problemas de idioma o una discapacidad y desea presentar una queja, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- Oficina de Derechos Civiles de Medi-Cal al 916-440-7370. Los usuarios de TTY deben llamar al 711.
- Departamento de Salud y Servicios Humanos de los EE. UU., Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

Vietnamese

Chúng tôi phải đảm bảo rằng tất cả các dịch vụ được cung cấp cho bạn một cách phù hợp với văn hóa và dễ tiếp cận. Chúng tôi cũng phải thông báo cho bạn về các quyền lợi của kế hoạch và quyền của bạn theo cách mà bạn có thể hiểu. Chúng tôi phải thông báo cho bạn về quyền của bạn mỗi năm khi bạn tham gia vào kế hoạch của chúng tôi.

- Để nhận thông tin theo cách mà bạn có thể hiểu, hãy gọi cho điều phối viên chăm sóc của bạn hoặc Dịch vụ Thành viên. Kế hoạch của chúng tôi có các dịch vụ thông dịch miễn phí để trả lời các câu hỏi bằng các ngôn ngữ khác nhau.
- Kế hoạch của chúng tôi cũng có thể cung cấp cho bạn tài liệu bằng các ngôn ngữ khác ngoài tiếng Anh, bao gồm tiếng Tây Ban Nha, Ả Rập, Armenia, Campuchia, Trung Quốc, Farsi, Hmong, Hàn Quốc, Lào, Nga, Tagalog và Việt Nam, và ở các định dạng như chữ in lớn, chữ nổi braille hoặc âm thanh. Để nhận tài liệu ở một trong những định dạng thay thế này, vui lòng gọi Dịch vụ Thành viên hoặc viết thư cho Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 7 ngày trong tuần, từ 8:00 sáng đến 8:00 tối, giờ địa phương. Đối với Dịch vụ Y tế: 200 Oceangate, Suite 100 Long Beach, CA 90802
- Để thực hiện yêu cầu thường xuyên nhận tài liệu bằng một ngôn ngữ khác ngoài tiếng Anh hoặc ở định dạng thay thế hiện tại và trong tương lai, vui lòng liên hệ với Dịch vụ Thành viên tại (855) 665-4627, TTY: 711 7 ngày trong tuần, từ 8:00 sáng đến 8:00 tối, giờ địa phương. Nếu bạn gặp khó khăn trong việc nhận thông tin từ kế hoạch của chúng tôi do vấn đề ngôn ngữ hoặc khuyết tật và bạn muốn nộp đơn khiếu nại, hãy gọi:
  - Medicare tại 1-800-MEDICARE (1-800-633-4227). Bạn có thể gọi 24 giờ một ngày, 7 ngày một tuần. Người dùng TTY nên gọi 1-877-486-2048.
  - Văn phòng Quyền công dân Medi-Cal tại số 916-440-7370. Người dùng TTY nên gọi 711.
  - Bộ Y tế và Dịch vụ Nhân sinh Hoa Kỳ, Văn phòng Quyền công dân tại số 1-800-368-1019. Người dùng TTY nên gọi 1-800-537-7697.

Arabic

يجب أن نضمن تقديم جميع الخدمات لك بطريقة تراعي الثقافة وتكون متاحة . كما يجب أن نخبرك بمزايا خطتنا وحقوقك بطريقة يمكنك فهمها . يجب أن نخبرك بحقوقك كل عام وأنت في خطتنا .
للحصول على المعلومات بطريقة يمكنك فهمها، اتصل بمنسق الرعاية الخاص بك أو بخدمات الأعضاء . خطتنا توفر خدمات الترجمة الفورية المجانية للإجابة على الأسئلة بلغات مختلفة .
يمكن لخطتنا أيضًا أن تقدم لك مواد بلغات غير الإنجليزية، بما في ذلك الإسبانية، العربية، الأرمينية، الكمبودية ، الصينية، الفارسية، الهمونغ، الكورية، اللاوية، الروسية، التغالوغية، والفيتنامية، وفي أشكال مثل الطباعة الكبيرة ، البرايل، أو الصوت . للحصول على المواد بإحدى هذه الأشكال البديلة، يرجى الاتصال بخدمات الأعضاء أو الكتابة إلى

طوال أيام Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711
الأسبوع، من الساعة 8:00 صباحًا حتى 8:00 مساءً، بالتوقيت المحلي . بالنسبة ل الخدمات الطبية : 200 Oceangate, Suite 100 Long Beach, CA 90802
لتقديم طلب دائم للحصول على المواد بلغة غير الإنجليزية أو في شكل بديل الآن وفي المستقبل، يرجى الاتصال بخدمات الأعضاء على 711 :TTY, 665-4627 (855) طوال أيام الأسبوع، من الساعة 8:00 صباحًا حتى 8:00 مساءً، بالتوقيت المحلي .
إذا كنت تواجه صعوبة في الحصول على المعلومات من خطتنا بسبب مشاكل في اللغة أو الإعاقة وترغب في تقديم شكوى، فاتصل ب :
Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. يمكنك الاتصال على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع . يجب على مستخدمي TTY الاتصال بالرقم 1-877-486-2048.
مكتب الحقوق المدنية ل Medi-Cal على الرقم 916-440-7370. يجب على مستخدمي TTY الاتصال بالرقم 711.
وزارة الصحة والخدمات الإنساني ة الأمريكية، مكتب الحقوق المدنية على الرقم 1-800-368-1019. يجب على مستخدمي TTY الاتصال بالرقم 1-800-537-7697.

Tagalog

Kailangang tiyakin namin na lahat ng mga serbisyo ay ibinibigay sa iyo sa isang paraang naaayon sa kultura at madaling ma-access. Kailangan din naming ipaalam sa iyo ang tungkol sa mga benepisyo ng aming plano at ang iyong mga karapatan sa paraang iyong maiintindihan. Kailangan naming ipaalam sa iyo ang tungkol sa iyong mga karapatan bawat taon na ikaw ay nasa aming plano.

- Upang makakuha ng impormasyon sa paraang iyong maiintindihan, tawagan ang iyong care coordinator o ang Serbisyo sa mga Miyembro. Ang aming plano ay may libreng mga serbisyo ng tagasalin upang sagutin ang mga tanong sa iba't ibang wika.
  - Maaari rin kaming magbigay ng mga materyales sa mga wikang iba sa Ingles, kabilang ang Espanyol, Arabe, Armenyo, Kambodyano, Tsino, Farsi, Hmong, Koreano, Lao, Ruso, Tagalog, at Vietnamese, at sa mga format tulad ng malalaking print, braille, o audio. Upang makakuha ng mga materyales sa isa sa mga alternatibong format na ito, mangyaring tawagan ang Serbisyo sa mga Miyembro o sumulat sa Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 7 araw sa isang linggo, mula 8:00 a.m. hanggang 8:00 p.m., lokal na oras. Para sa Mga Serbisyong Medikal: 200 Oceangate, Suite 100 Long Beach, CA 90802

Upang gumawa ng palagiang kahilingan para makakuha ng mga materyales sa isang wika na iba sa Ingles o sa isang alternatibong format ngayon at sa hinaharap, mangyaring makipag-ugnayan sa Serbisyo sa mga Miyembro sa (855) 665-4627, TTY: 711 7 araw sa isang linggo, mula 8:00 a.m. hanggang 8:00 p.m., lokal na oras.

Kung mayroon kang kahirapan sa pagkuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at nais mong magsumite ng reklamo, tawagan ang:

Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kang tumawag 24 oras sa isang araw, 7 araw sa isang linggo. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-877-486-2048.

Medi-Cal Office of Civil Rights sa 916-440-7370. Ang mga gumagamit ng TTY ay dapat tumawag sa 711.

U.S Department of Health and Human Services, Office for Civil Rights sa 1-800-368-1019. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-800-537-7697.

Armenian

Մենք պետք է համոզվենք, որ բոլոր ծառայությունները ձեզ են մատուցվում մշակութային համապատասխան և հասանելի եղանակով: Մեր պլանի օգուտների և ձեր իրավունքների մասին պետք է տեղեկացնենք ձեզ այնպիսի ձևով, որ կարողանաք հասկանալ: Մենք պետք է տեղեկացնենք ձեզ ձեր իրավունքների մասին ամեն տարի, երբ դուք գտնվում եք մեր պլանում:

Մատչելի ձևաչափով տեղեկություններ ստանալու համար զանգահարեք ձեր խնամքի համակարգողին կամ Մասնակիցների Ծառայությանը: Մեր պլանը ունի անվճար թարգմանչական ծառայություններ տարբեր լեզուներով հարցերին պատասխանելու համար:

- Մեր պլանը նաև կարող է ձեզ տրամադրել նյութեր անգլերենից բացի այլ լեզուներով, այդ թվում՝ իսպաներեն, արաբերեն, հայերեն, քամբոջերեն, չինարեն, փարսի, հմոնգ, կորեերեն, լաո, ռուսերեն, տագալոգ և վիետնամերեն, ինչպես նաև մեծ տպագրությամբ, բրեյլով կամ աուդիո ձևաչափով: Հնարավորության դեպքում ստանալու համար այս այլընտրանքային ձևաչափերից մեկում նյութեր, խնդրում ենք զանգահարել Մասնակիցների Ծառայությանը կամ գրել Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 7 օր շաբաթվա ընթացքում, 8:00-ից մինչև 20:00, տեղական ժամանակ. Առողջապահական ծառայությունների համար՝ 200 Oceangate, Suite 100 Long Beach, CA 90802
- Եթե ցանկանում եք մշտապես ստանալ նյութեր անգլերենից բացի այլ լեզուներով կամ այլընտրանքային ձևաչափով այժմ և ապագայում, խնդրում ենք դիմել Մասնակիցների Ծառայությանը (855) 665-4627, TTY: 711 7 օր շաբաթվա ընթացքում, 8:00-ից մինչև 20:00, տեղական ժամանակ:

Եթե դժվարություններ եք ունենում մեր պլանից տեղեկատվություն ստանալու հարցում լեզվաբառերի կամ հաշմանդամության պատճառով և ցանկանում եք ներկայացնել բողոք, զանգահարեք:

Medicare հեռախոսահամարով 1-800-MEDICARE (1-800-633-4227). Դուք կարող եք զանգահարել 24 ժամ ցերեկով, 7 օր շաբաթվա ընթացքում: TTY օգտվողները պետք է զանգահարեն 1-877-486-2048:

Medi-Cal Քաղաքացիական իրավունքների գրասենյակ՝ 916-440-7370. TTY օգտվողները պետք է զանգահարեն 711:

ԱՄՆ Առողջապահության և մարդկային ծառայությունների նախարարություն, Քաղաքացիական իրավունքների գրասենյակ՝ 1-800-368-1019. TTY օգտվողները պետք է զանգահարեն 1-800-537-7697:

Cambodian

យើងត្រូវតែធ្វើការធានាថាសេវាកម្មទាំងអស់ត្រូវបានផ្តល់ឱ្យអ្នកក្នុងរបៀបដែលឆបគ្នានឹងវប្បធម៌ និងអាចចូលដំណើរការបាន។

យើងត្រូវតែប្រាប់អ្នកអំពីអត្ថប្រយោជន៍នៃផែនការរបស់យើង និងសិទ្ធិរបស់អ្នកក្នុងរបៀបដែលអ្នកអាចយល់បាន។ យើងត្រូវតែប្រាប់អ្នកអំពីសិទ្ធិរបស់អ្នករៀងរាល់ឆ្នាំដែលអ្នកនៅក្នុងផែនការរបស់យើង។

ដើម្បីទទួលព័ត៌មានក្នុងរបៀបដែលអ្នកអាចយល់បាន សូមទំនាក់ទំនងទៅកាន់អ្នករៀបចំការថែទាំរបស់អ្នក ឬសេវាកម្មសមាជិក។ ផែនការរបស់យើងមានសេវាកម្មបកប្រែ ឥតគិតថ្លៃសម្រាប់ឆ្លើយសំណួរជាភាសាផ្សេងៗ។

- ផែនការរបស់យើងក៏អាចផ្តល់ឱ្យអ្នកនូវឯកសារជាភាសាផ្សេងទៀតក្រៅពីភាសាអង់គ្លេសមានភាសាអេស្ប៉ាញ ភាសាអារ៉ាប់ ភាសាអាមេនី ភាសាកម្ពុជា ភាសាចិន ភាសាហ្វារ្ស៊ី ភាសាហ្មុង ភាសាកូរ៉េ ភាសាឡាវ ភាសារុស្ស៊ី ភាសាតាហ្គាឡុក និងភាសាវៀតណាម និងក្នុងទម្រង់ទ្រង់ ដូចជា៖ អក្សរធំ អក្សរស្ទាប ឬទម្រង់អូឌីយ៉ូ។ ដើម្បីទទួលបានឯកសារនៅក្នុងទម្រង់ផ្សេងទៀតទាំងនេះ សូមទំនាក់ទំនងទៅកាន់សេវាកម្មសមាជិក ឬសរសេរទៅ Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 7 ថ្ងៃក្នុងមួយសប្តាហ៍ ម៉ោង 8:00 ព្រឹក ដល់ 8:00 ល្ងាច ម៉ោងក្នុងតំបន់។ សម្រាប់ សេវាកម្មសុខាភិបាល៖ 200 Oceangate, Suite 100 Long Beach, CA 90802
- ដើម្បីធ្វើការស្នើរសុំជាប្រចាំដើម្បីទទួលបានឯកសារជាភាសាផ្សេងទៀតក្រៅពីភាសាអង់គ្លេស ឬក្នុងទម្រង់ផ្សេងទៀតឥឡូវនេះ និងនៅពេលអនាគត សូមទំនាក់ទំនងទៅកាន់សេវាកម្មសមាជិកនៅ (855) 665-4627, TTY: 711 7 ថ្ងៃក្នុងមួយសប្តាហ៍ ម៉ោង 8:00 ព្រឹក ដល់ 8:00 ល្ងាច ម៉ោងក្នុងតំបន់។

យបិនេអនកមានបញ្ហានឹងការទិទ្ធិលានរ៉ាមានីតផ្នការរប់យើងយា សារបញ្ហាភាសា ឬការបងក៉ារតេគប់តុគង និងអនកចង៉ាក់បតឹង រូម្ទីនាក់ទីនងយ៉ាកាន់ះ

- Medicare យលខទិូរ័ទ 1-800-MEDICARE (1-800-633-4227). អនកអាចទក់ទិងាន 24 យម៉ាងកនុងមួ នរ៉ី 7 នរ៉ីកនុងមួ ពតហ្ន៍។ អនកយតុបី TTY គួរតរទីនាក់ទីនងយ៉ា 1-877-486-2048។
- ការិល័ទិធរីលរប់ Medi-Cal យលខ 916-440-7370។ អនកយតុបី TTY គួរតរទីនាក់ទីនងយ៉ា 711។
- តុកូងេ ខាភិាល និងយរោកមុមមុន រេប់អោយម៉ូរិក, ការិល័ទិធរីល យលខ 1-800-368-1019។ អនកយតុបី TTY គួរតរទីនាក់ទីនងយ៉ា 1-800-537-7697។

Chinese

- 我们必须确保所有服务都以符合文化的和易于接触的方式提供给您。我们还必须以 您能理解的方式告知您我们计划的福利和您的权利。我们必须每年告知您有关您权 利的信息，只要您在我们的计划中。

要以您能理解的方式获取信息，请致电您的护理协调员或会员服务。我们的计划提供 免费的翻译服务，以回答不同语言的问题。

- 我们的计划还可以提供除英语外的其他语言的材料，包括西班牙语、阿拉 伯语、亚美尼亚语、柬埔寨语、中文、波斯语、苗语、韩语、老挝语、俄 语、塔加洛语和越南语，以及大字印刷、盲文或音频格式。要以这些替代 格式之一获取材料，请拨打会员服务电话或写信给 Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 每周7天，上午 8:00至晚上8:00，当地时间。医疗服务地址：200 Oceangate, Suite 100 Long Beach, CA 90802
- 要现在及将来持续请求以非英语语言或其他替代格式获取材料，请联系会 员服务 (855) 665-4627, TTY: 711 每周7天，上午8:00至晚上8:00，当地时 间。

如果由于语言问题或残疾而无法从我们的计划中获得信息，并且您希望提出投诉，请拨打：

Medicare 电话号码 1-800-MEDICARE (1-800-633-4227)。您可以全天候拨打，每周7天。TTY用户应拨打 1-877-486-2048。

Medi-Cal 公民权利办公室电话 916-440-7370。TTY 用户应拨打 711。

美国卫生与公共服务部，公民权利办公室电话 1-800-368-1019。TTY 用户应 拨打 1-800-537-7697。

Farsi

- میشود ارائه شما به دسترسی قابل و مناسب فرهنگی صورت به خدمات تمامی که کنیم حاصل اطمینان باید ما . همچنین باید به شما در مورد مزایای طرح ما و حقوق شما به گونهای که بتوانید درک کنید، اطلاعات دهیم . ما باید هر سال که در طرح ما هستید، به شما درباره حقوقتان اطلاع دهیم .
- تماس اعضا خدمات یا مراقبت هماهنگکننده با کنید، درک بتوانید که گونهای به اطلاعات دریافت برای بگیرید . طرح ما خدمات ترجمه رایگان برای پاسخ به سوالات به زبانهای مختلف ارائه میدهد .
- کامبوجی ارمنی، عربی، اسپانیایی، جمله از انگلیسی، از غیر زبانهای به را مواد میتواند همچنین ما طرح ، چینی، فارسی، هزارهای، کرهای، لائوسی، روسی، تاگالوگ و ویتنامی، و در فرمتهایی مانند چاپ بزرگ ، بریل یا صوتی ارائه دهد . برای دریافت مواد به یکی از این فرمتهای جایگزین، لطف اً با خدمات اعضا تماس بگیرید یا به Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 روز هفته، از ساعت 8:00 صبح تا 8:00 شب، به وقت محلی نامه بنویسید . برای خدمات پزشکی : 200 Oceangate, Suite 100 Long Beach, CA 90802
- ا لطف اً آینده، در و اکنون جایگزین فرمت در یا انگلیسی از غیر زبان به مواد دریافت دائمی درخواست برای خدمات اعضا تماس بگیرید 711 :TTY, 665-4627 (855) 7 روز هفته، از ساعت 8:00 صبح تا 8:00 شب، به وقت محلی .
- کنید شکایت میخواهید و کنید بهرهبرداری ما طرح اطلاعات از نتوانید ناتوانی یا زبان مشکلات دلیل به اگر ، تماس بگیرید به :

- Medicare به شماره 1-800-MEDICARE (1-800-633-4227). شما میتوانید به صور ت 24 ساعته در روز، 7 روز هفته تماس بگیرید . کاربران TTY باید به شماره 1-877-486-2048 تماس بگیرند .
- دفتر حقوق مدنی Medi-Cal به شماره 916-440-7370. کاربران TTY باید به شماره 711 تماس بگیرند .
- وزارت بهداشت و خدمات انسانی ایالات متحده،

Korean

우리는 모든 서비스가 문화적으로 적합하고 접근 가능한 방식으로 제공되도록 해야 합니다. 또한 우리의 계획의 혜택과 당신의 권리에 대해 이해할 수 있는 방식으로 알려야 합니다. 당신이 우리 계획에 있는 매년 당신의 권리에 대해 알려야 합니다.

- 이해할 수 있는 방식으로 정보를 얻으려면, 귀하의 치료 조정자 또는 회원 서비스에 연락하십시오. 우리 계획은 다양한 언어로 질문에 답변할 수 있는 무료 통역 서비스를 제공합니다.
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  - 영어 외의 언어 또는 대체 형식으로 자료를 지속적으로 받으려면 지금 및 미래에 대해 회원 서비스에 (855) 665-4627, TTY: 711 매일 8:00 AM에서 8:00 PM까지, 지역 시간으로 연락해 주십시오.
- 언어 문제나 장애로 인해 우리 계획에서 정보를 얻는 데 어려움을 겪고 있고 불만을 제기하고 싶다면 다음으로 연락하십시오:
- Medicare: 1-800-MEDICARE (1-800-633-4227). 하루 24시간, 주 7일 언제든지 연락할 수 있습니다. TTY 사용자는 1-877-486-2048로 연락해야 합니다.
- Medi-Cal 시민 권리 사무소: 916-440-7370. TTY 사용자는 711로 연락해야 합니다.
- 미국 보건복지부, 시민 권리 사무소: 1-800-368-1019. TTY 사용자는 1-800-537-7697로 연락해야 합니다.

Russian

Мы должны обеспечить, чтобы все услуги предоставлялись вам культурно компетентным и доступным способом. Мы также должны сообщить вам о преимуществах нашего плана и ваших правах так, чтобы вы могли понять. Мы должны информировать вас о ваших правах каждый год, пока вы находитесь в нашем плане.

Чтобы получить информацию в понятной вам форме, позвоните вашему координатору по уходу или в службу поддержки членов. Наш план предоставляет бесплатные услуги перевода для ответов на вопросы на различных языках.

- Наш план также может предоставить материалы на языках, отличных от английского, включая испанский, арабский, армянский, кхмерский, китайский, фарси, хмонг, корейский, лаосский, русский, тагальский и вьетнамский, а также в таких форматах, как крупный шрифт, шрифт Брайля или аудио. Чтобы получить материалы в одном из этих альтернативных форматов, пожалуйста, позвоните в службу поддержки членов или напишите в Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711 7 дней в неделю, с 8:00 до 20:00 по местному времени. Для медицинских услуг: 200 Oceangate, Suite 100 Long Beach, CA 90802

- Чтобы сделать постоянный запрос на получение материалов на языке, отличном от английского, или в альтернативном формате сейчас и в будущем, пожалуйста, свяжитесь со службой поддержки членов по телефону (855) 665-4627, TTY: 711 7 дней в неделю, с 8:00 до 20:00 по местному времени.

- Если у вас возникли трудности с получением информации от нашего плана из-за языковых проблем или инвалидности и вы хотите подать жалобу, позвоните:
  - Medicare по номеру 1-800-MEDICARE (1-800-633-4227). Вы можете звонить круглосуточно, 7 дней в неделю. Пользователи TTY должны звонить по номеру 1-877-486-2048.
  - Офис гражданских прав Medi-Cal по номеру 916-440-7370. Пользователи TTY должны звонить по номеру 711.
  - Офис гражданских прав Министерства здравоохранения и социальных служб США по номеру 1-800-368-1019. Пользователи TTY должны звонить по номеру 1-800-537-7697.

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

If you have a hard time getting care, contact Member Services at 1-866-314-2427, TTY: 711, 8 a.m. – 8 p.m. PST. You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call your care coordinator or Member Services or look in 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 is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (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 your *Member Handbook*.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of your *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

Chapter 9 of your *Member Handbook* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

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

We protect your PHI as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights 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 are not required to obtain any other member's authorization to receive sensitive services or to submit a claim for sensitive services. Central Health Medi-Medi Plan I (HMO D-SNP) will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Central Health Medi-Medi Plan I (HMO D-SNP) will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care.

Central Health Medi-Medi Plan I (HMO D-SNP) will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

C1. How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We may release PHI if ordered by a court, but only if it is allowed by California law.
- We must give Medicare your PHI. 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.
- 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.

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

D. Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. We can also give you written materials and/or information in Arabic, Armenian, Cambodian, Chinese, Farsi, Hmong, Korean, Russian, Tagalog, and Vietnamese.

We can also give you information in large print, braille, or audio. To make a standing request to get materials in a language other than English or in an alternate format now and in the future, please contact Member Services at the number at the bottom of the page.

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

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

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Member Handbook*.

F. Your right to leave our plan

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

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Member Handbook:*
  - For more information about when you can join a new MA or prescription drug benefit plan.
  - For information about how you will get your Medi-Cal benefits if you leave our plan.

G. Your right to make decisions about your health care

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

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

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about 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 will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

For more information, call Central Health Medi-Medi Plan I (HMO D-SNP) at 1-866-314-2427, TTY: 711, 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). The call is free.

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

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

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

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

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Central Health Medi-Medi Plan I (HMO D-SNP) will tell you about changes to the state law no later than 90 days after the change.

Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with Ombuds Program 1-855-501-3077. This call is free. TTY: 1-855-847-7914. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.

Write: **Department of Health Care Services**
1501 Capitol Avenue PO Box 997413, Sacramento, Ca 95814

Website: http://calduals.org/background/cci/archive/policy/cal-mediconnect-ombudsman/

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

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

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

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

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

- Member Services.
- The Health Insurance Counseling and Advocacy Program (HICAP) at (714) 560-0424For more details about HICAP, refer to **Chapter 2**.
- Los Angeles county: (213) 383-4519
- Sacramento county: (800) 434-0222
- San Diego county: (858) 565-8772
- Imperial county: (760) 353- 0223
- Riverside and San Bernardino county: (909) 256-8369
- The Ombuds Program at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of your *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

I. Your responsibilities as a plan member

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

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your 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 of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most Central Health Medi-Medi Plan I (HMO D-SNP) members, Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call your care coordinator or Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* advises you about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- **Call your care coordinator or Member Services for help if you have questions or concerns.**

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

Introduction

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

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Medicare Medi-Cal Ombuds Program at 1-855-501-3077 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of your *Member Handbook.*

Table of Contents

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

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

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

A1. About the legal terms

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

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (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 the Health Insurance Counseling and Advocacy Program

You can call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do about your problem. HICAP is not connected with us or with any insurance company or health plan. HICAP has trained counselors in every county, and services are free. The HICAP phone number is 1-800-434-0222.

Help from the Medicare Medi-Cal Ombuds Program

You can call the Medicare Medi-Cal Ombuds Program and speak with an advocate about your health coverage questions. They offer free legal help. The Ombuds Program is not connected with us or with any insurance company or health plan. Their phone number is 1-855-501-3077, and their website is www.healthconsumer.org.

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

- Visit the Medicare website (www.medicare.gov).

Help and information from Medi-Cal

Call: (916) 449-5000, Monday - Friday, 8:00 a.m. - 5:00 p.m., local time.

Help from the California Department of Health Care Services

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

Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care (DMHC) for free help. The DMHC is responsible for overseeing health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is **1-888-466-2219.** Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, **1-877-688-9891.** You can also visit DMHC's website at **www.dmhc.ca.gov.** The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-866-314-2427, 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** of 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 cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The 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 prescription drugs) are covered or not, the way they are 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 is not about benefits or coverage. Refer to **Section K,** "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B prescription drugs as **medical care.**

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. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from them (refer to **Chapter 4, Section G** of your *Member Handbook*).

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

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

E2. Appeals

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

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

In most cases, you must start your appeal at Level 1. If your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an 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, 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 will 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 your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

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

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Medicare Medi-Cal Ombuds 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 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.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your "representative" and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
  - Ask for a legal aid attorney from the Medicare Medi-Cal Ombuds Program at 1-855-501-3077.

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

Call Member Services at the numbers listed 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 https://centralhealthplan.com/Member/AppointRep. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

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

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

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

F. Medical Care

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

This section is about your benefits for medical care that is described in **Chapter 4** of your *Member Handbook*. In some cases, different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

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

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

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

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

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

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

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

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

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

   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 are experiencing delays in care or you cannot 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: 1-866-314-2427, TTY: 711.
- faxing: (844) 834-2155
- writing: Attn: Medicare Member Services, 200 Oceangate Ste. 100, Long Beach, CA 90802

Standard coverage decision

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

- Medical service or item within 14 calendar days after we get your request. For Knox-Keene plans, within 5 business days, and no later than 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

Fast coverage decision

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

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

- Medical service or item within 72 hours after we get your request, or sooner if your medical condition requires a quicker response.
- Medicare Part B prescription drug within 24 hours after we get your request.

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

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

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

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

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

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

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

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

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

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 1-866-314-2427, TTY: 711, 8 a.m. – 8 p.m. PST.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-866-314-2427, TTY:711.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMSForms/downloads/cms1696.pdf or on our website at https://centralhealthplan.com/Member/AppointRep.
- 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 that you did not get, you and/or your doctor decide if you need a fast appeal.

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

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

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

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

We consider your appeal and give you our answer.

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

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response**. We will give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. In California a State Hearing is called State Fair Hearing. To file a State Hearing, refer to www.cdss.ca.gov.
- **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 prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
  - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. In California a State Hearing is called State Fair Hearing. To file a State Hearing, refer to www.cdss.ca.gov.

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 7 calendar days of the date we got your appeal if your request is for a Medicare Part B prescription 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 will send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.

- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state. However, an Independent Medical Review is not 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 10 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 72hours** 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 prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 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 **5 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 prescription drug, we must authorize or provide the Medicare Part B prescription 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 should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (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) Independent Medical Review

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by experts who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours, or sooner, if your health requires it, for a fast appeal.

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

of Managed Health Care 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 are entitled to both an IMR and a State Hearing, but you are not entitled to an IMR if you have already presented evidence in a State Hearing or had a State Hearing on the same issue.

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 file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

If your treatment was denied because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR.

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

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months, or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: www.dmhc.ca.gov/FileaComplaint/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 cannot return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Mail or fax your forms and any attachments to:

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

- You may also submit your Independent Medical Review Application/Complaint Form and Authorized Assistant form online: www.dmhc.ca.gov/FileaComplaint.aspx

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

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 48 hours of receipt of a completed application telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within

3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

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

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

(2) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the “Appeal Decision Letter” notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read “Will my benefits continue during Level 2 appeals” on section F4 for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
    - To the county welfare department at the address shown on the notice.
    - To the California Department of Social Services:

    State Hearings Division
    P.O. Box 944243, Mail Station 9-17-433
    Sacramento, California 94244-2430

    - To the State Hearings Division at fax number 916-309-3487 or toll-free at 1-833-281-0903.
2. You can call the California Department of Social Services at 1-800-743-8525. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

The State Hearings Division gives you their decision in writing and explain the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

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

The letter you get from the State Hearings Division describes the next appeal option.

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

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay 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 are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you ***or*** your provider the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request. Your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

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

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

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will 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 should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medi-Cal usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to 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 your *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 is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

> An initial coverage decision about your 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 is 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 your *Member Handbook* for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (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.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

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

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

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

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-866-314-2427, 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 about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

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

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

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

A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

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

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

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you we will use the standard deadline. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

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

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

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

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

- We must give you our answer within 14 calendar days after we get your request.

- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** 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 1-866-314-2427, 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** 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** for information about the review organization and the Level 2 appeals process.

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

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

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

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

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

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If 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 1-866-314-2427, 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** 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 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level

2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this **Section H**, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (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 are not part of our plan.

In California, the QIO is Livanta (California's Quality Improvement Organization). Call them at (855) 887-6668 TTY: 711. Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2.**

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- 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 is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will 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 (855) 887-6668 TTY: 711.

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 will provide your covered inpatient hospital services for as long as the services are medically necessary.

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

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section E4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it**. If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.
  - Call the HICAP at 1-800-434-0222.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the 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 will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/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 will provide your covered services for as long as they are 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 (855) 887-6668 TTY: 711.

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 will provide coverage for the care for as long as it is medically necessary.

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

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to **Section F4** to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If 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 will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the 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 appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an 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, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
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 Member Services at the numbers listed at the bottom of this page.

The legal term for a "complaint" is a "**grievance**."

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

K2. Internal complaints

To make an internal complaint, call Member Services at 1-866-314-2427, TTY: 711. You can make the complaint at any time unless it is 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 is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- Grievances may only be resolved orally in cases that do not involve a coverage dispute, disputed health care service involving medical necessity or experimental/investigational treatment and which are resolved by close of business the next day. All other grievances, oral or in writing, must be acknowledged and responded to in writing. You can call us at 1-866-314-2427, TTY: 711, 7 days a week, 8:00 a.m. to 8:00 p.m., local time; or write to us at Central Health Medi-Medi Plan I (HMO D-SNP), PO Box 22816, Long Beach, CA 90801, Fax: (562) 499-0610.

The legal term for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with Central Health Medi-Medi Plan I (HMO D-SNP) before filing a complaint with Medicare.

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

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Medi-Cal

You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. For non-urgent matters, you may file a complaint with the DMHC if you disagree with the decision in your Level 1 appeal or if the plan has not resolved your complaint after 30 calendar days. However, you may contact the DMHC without filing a Level 1 appeal if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan's decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not 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:

(877) 588-1123,

Monday to Friday: 9:00 a.m. to 5:00 p.m. (local time), 24 hour voicemail is available.

TTY: (855) 887-6668

https://www.livantaqio.com/en/states/california. You may also have rights under the Americans with Disability Act (ADA). You can contact the local OCR office at 1-877-588-1123.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In California, the QIO is called Livanta (California's Quality Improvement Organization. Telephone number for Livanta is (877) 588-1123.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

Table of Contents

A. When you can end your membership in our plan

You may be able to end your membership because you have Medicare and Medi-Cal.

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 any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (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 are 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 change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

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

- Medicare options in the table in **Section C1**.
- Medi-Cal options and services in **Section C2**.

You can get more information about how you can end your membership by calling: Member Services at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434- 0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP. Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

B. How to end membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. 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 5
- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medi-Cal services separately

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual 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: **A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It is 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.** **Note:** The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medi-Medi Plan. You are automatically 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: **Original Medicare with a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. You are automatically disenrolled from our plan when your Original Medicare coverage begins.
4. You can change to: **Any Medicare health plan** during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in Section A.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal Plan may change.

C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

D. 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 prescription 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 are hospitalized on the day that your membership in Central Health Medi-Medi Plan I (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and 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 are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
  - Refer to **Chapter 4** of your *Member Handbook* for information on getting care through our visitor or traveler benefits when you're away from our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your 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 cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

Chapter 11: Legal notices

Introduction

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

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A. Notice about laws

The principal law that applies to this Evidence of Coverage document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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 do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition. 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.

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 have been discriminated against and want to file a discrimination grievance, contact 1-866-314-2427, TTY: 711 or write Medicare Appeals and Grievances P.O. Box 22816 Long Beach, CA 90801.

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 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 www.dhcs.ca.gov/Pages/Language_Access.aspx.
- Electronically: Send an email to CivilRights@dhcs.ca.gov.

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

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

D. 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 cannot exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at www.dhcs.ca.gov/er or call 916-650-0590.

Chapter 12: Definitions of important words

Introduction

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

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: 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 do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorder services.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins.There is no limit to the number of benefit periods.

Biological Product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also "Original Biological Product" and "Biosimilar").

Biosimilar: A biological drug that is 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. (See "Interchangeable Biosimilar").

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to "Individualized Care Plan."

Care Plan Optional Services (CPO Services): Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Medi-Cal.

Care team: Refer to "Interdisciplinary Care Team."

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

Community-Based Adult Services (CBAS): Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance".

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

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

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Department of Health Care Services (DHCS): The state department in California that administers the Medicaid Program (known as Medi-Cal).

Department of Managed Health Care (DMHC): The state department in California responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug 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 tier.

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 are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is 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 are not covered by this health plan.

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

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health Insurance Counseling and Advocacy Program (HICAP): A program that provides free and objective information and counseling about Medicare. **Chapter 2** of your *Member Handbook* explains how to contact HICAP.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

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

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.

In Home Supportive Services (IHSS): The IHSS Program will help pay 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. 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 doctors who are not part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not 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**.

Independent Physician Association (IPA): An IPA is a company contracted by Central Health Medi-Medi Plan I (HMO D-SNP) that organizes a group of doctors, specialists, and other providers of health services to see Central Health Medi-Medi Plan I (HMO D-SNP) Members. Your doctor, along with the IPA, takes care of all your medical needs. This includes getting authorization, if it is required,

to see specialist doctors or receive medical services such as lab tests, x-rays, and inpatient and outpatient hospital services.

Individualized Care Plan (ICP or Care Plan): A care plan includes your main health concern, goals, needs and services you may need Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient or receiving observation services instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team includes your Primary Care Physician, Case Manager, may include other specialty care providers, Caregiver, or other health professionals who are there to help you get the care you need. Your care team will also help you make or update your care plan.

Integrated D-SNP: A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan 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 related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

***List of Covered Drugs* (*Drug List*):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS covered by our plan include Community-Based Adult Services (CBAS), also known as adult day health care, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.

Low-income subsidy (LIS): Refer to "Extra Help"

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medi-Cal: This is the name of California 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.

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.

Medically necessary: This describes the needed services, supplies, or drugs you need to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice or are otherwise necessary under current Medicare or Medi-Cal coverage rules.

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 of 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 prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

Medi-Medi Plan: A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It is 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.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

Nursing home or facility: A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of your *Member Handbook* explains coverage decisions.

Original Biological Product: A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

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

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): A Service Request that is submitted by your PCP in order to get approval or authorization from Central Health Medi-Medi Plan I (HMO D-SNP) for a specific service or drug or use an out-of-network provider. Central Health Medi-Medi Plan I (HMO D-SNP) may not cover the service or drug if you don't get approval.

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 your *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 for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

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

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

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 your *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Specialized pharmacy: Refer to **Chapter 5** of your *Member Handbook* to learn more about specialized pharmacies.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you cannot get to them because given your time, place, or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).

Central Health Medi-Medi Plan I (HMO D-SNP) Member Services

CALL	1-866-314-2427Calls to this number are free., 8 a.m. – 8 p.m. PST, 7 days a week (October 1 – March 31) & Monday – Friday (April 1 – September 30). Member Services also has free language interpreter services available for non-English speakers.
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. Monday - Friday, 8:00 a.m. to 8:00 p.m., local time.
WRITE	**For Medical Services:** 200 Oceangate, Suite 100 Long Beach, CA 90802 **For Part D (Rx) Services:** Attn: Pharmacy Department 7050 Union Park Center, Suite 200 Midvale, UT 84047

WEBSITE	www.centralhealthplan.com

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WEBSITE	www.centralhealthplan.com