<Delegate Logo>

Coverage Decision Letter

<Date>

Member Name:

Member ID:

Plan Name: Blue Shield TotalDual Plan (HMO D-SNP) H5928-005

Requested Service:

Reference Number:

Requesting Provider:

<Provider Organization/Blue Shield TotalDual Plan (HMO D-SNP)> is called "our plan" or "we" in this letter. We are a health plan that contracts with Medicare and Medi-Cal to provide coverage for both programs. Our plan coordinates your Medicare and Medi-Cal services and your doctors, hospitals, pharmacies, and other health care providers.

Our provider organization/plan <denied *or* partially denied *or* reduced *or* stopped *or* suspended> the <service *or* item> listed below:

[*Insert description of service or item being denied, partially denied, reduced, stopped, or suspended, and include doctor or provider's name if a particular doctor or provider requested the service or item.*]

Our provider organization/plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision. Write rationale in plain language – see instructions for more information*].

You have the right to appeal our decision

You can appeal our plan's decision. Share this letter with your health care provider and ask about next steps. If you appeal and our plan changes its decision, we may pay for the <service *or* item>.

You can also call Customer Care at (800) 452-4413 (TTY:711) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your health care provider to help you decide if you should appeal.

You must appeal by [*Insert specific appeal filing deadline date in month, date, year format – 60 calendar days from date of letter. Insert deadline date in bold text*]**.** Our plan may give you more time if you have a good reason.

There are two kinds of appeals

Our plan has two kinds of appeals – standard appeals and fast appeals.

1. If you ask for a **standard appeal**, our plan will send you a written decision within **30 calendar days after we get your appeal**.

2. If you ask for a **fast appeal**, our plan will give you a decision within **72 hours after we get your appeal**. You can ask for a fast appeal if you or your health care provider believe your health could be **seriously harmed** by waiting up to [*for a Part B drug, insert:* **7 calendar days** *or for any other service or item, insert:* **30 calendar days** for a decision. **Note**: You can't get a fast appeal if our plan denied payment for a service you already got.

   Our plan will **automatically** give you a fast appeal if your **health care provider asks for one for you** or if your **health care provider supports your request**. If you ask for a fast appeal without support from a health care provider, our plan will decide if you can get a fast appeal. If our plan doesn't approve a fast appeal, we'll give you a decision on your appeal within [*for a Part B drug, insert:* **7 calendar days** *or for any other service or item, insert:* **30 calendar days**.

[*Delete if the letter is for a denial of a Part B drug:* For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.

How to appeal

You, someone you have named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or your health care provider can appeal. You can contact our plan to appeal in one of these ways:

- **Phone**: Call 800-452-4413 (TTY:711)
- **Fax**: Send a fax to 916-350-6510

- **Mail**: Mail it to

  Blue Shield of California
  Medicare Appeals and Grievances Department
  P.O. Box 927
  Woodland Hills, CA 91365-9856

- In-person delivery address

  Blue Shield of California
  Medicare Appeals and Grievances Department
  6300 Canoga Avenue
  Woodland Hills, CA 91367

If you appeal in writing, keep a copy. If you call, we'll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

- Your name
- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with our plan
- The reason(s) you're appealing our decision
- If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
- Anything you want our plan to look at that shows why you need the <service *or* item>. For example, you can send us:
  - Medical records from your health care provider,
  - Letters from your health care provider (such as a statement from your health care provider that says why you need a fast appeal), or
  - Other information that says why you need the <service *or* item>

To get more information on how to appeal, call Customer Care at 800-452-4413 (TTY: 711). You can also find more information in our plan's [*insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*], [*plans may insert chapter and/or section reference, as applicable*]. An up-to-date copy of the

[*insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses*] is always available on our website at <web address> or by calling our plan.

How to keep getting your <service *or* item> during your appeal

If you're already getting the <service *or* item> listed on the first page of this letter, you can ask to keep getting it during your appeal.

- **You must appeal and ask our plan to continue getting your <service *or* item> by** [*Insert continuation of benefits request filing date in month, date, year format. Date will be the later of the following: (1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state) or (2) date the decision takes effect. Insert date in bold text*]**.**
- See the "How to appeal" section earlier in this letter for information about how to contact our plan.
- If you ask our plan to continue your <service *or* item> by [*Insert continuation of benefits request filing date*], your <service *or* item> will stay the same during your appeal.
- If your health care provider is filing the appeal for you and you want to keep getting your <service *or* item>, then your health care provider must include your written consent.

What happens next

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies the <service *or* item> listed on the first page of this Coverage Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask State of California for a Fair Hearing (also called a State Hearing).

What to do if you need help with your appeal

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your "representative" by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

- Call our plan at **(800) 452-4413 (TTY: 711)** to learn how to name that person as your representative. Or, you can visit **Medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me**.

- You and your representative must sign and date a statement that says this is what you want.
- Mail or fax the signed statement to us at:

  Mailing Address:
  Blue Shield of California
  Medicare Appeals and Grievances Department
  P.O. Box 927
  Woodland Hills, CA 91365-9856

- Fax: 916-350-6510
- Keep a copy.

Get help and more information

- Blue Shield TotalDual Plan (HMO D-SNP) Customer Care: Call 800-452-4413 (TTY:711), 8a.m. to 8 p.m., seven (7) days a week. You can also visit **www.blueshieldca.com/medicare**
- Medicare Medi-Cal Ombudsman Program (also called the Cal MediConnect Ombudsman): Call 1-855-501-3077 (TTY: 1-855-847-7914). Medicare Medi-Cal Ombudsman Program can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren't connected with our plan or with any insurance company or health plan. Their services are free.
- California Health Insurance Counseling & Advocacy Program (HICAP)**:** Call 1-800-434-0222 (TTY:711). California Health Insurance Counseling & Advocacy Program (HICAP) counselors can help you with Medicare issues, including how to appeal. California Health Insurance Counseling & Advocacy Program (HICAP) isn't connected with any insurance company or health plan. Their services are free.
- **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit **Medicare.gov**.
- Medi-Cal: Call 1-800-430-4263 (TTY:1-800-430-7077).
- **Medicare Rights Center:** Call 1-800-333-4114, or visit **www.medicarerights.org**.
- **Eldercare Locator**: Call 1-800-677-1116, or visit **www.eldercare.acl.gov** to find help in your community.

You can get this document for free in Spanish, Arabic, Armenian, Chinese, Farsi, Khmer, Korean, Russian, Tagalog, and Vietnamese, or other formats, such as large print, braille, or audio. Call (800) 452-4413 and TTY: 711, 8a.m. to 8 p.m., seven (7) days a week. The call is free.

Enclosure(s):
“Notice of Non-Discrimination”
“Language Assistance Notice”