

2022

Evidence of Coverage/ Member Handbook

Blue Shield Promise Cal MediConnect Plan
(Medicare-Medicaid Plan)
Los Angeles County

Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association
CMC-EOC-LA-EN-1021



Promise Health Plan

January 01, 2022 – December 31, 2022

Your Health and Drug Coverage under Blue Shield Promise Cal MediConnect Plan

Member Handbook Introduction

This handbook tells you about your coverage under Blue Shield Promise Cal MediConnect Plan through December 31, 2022. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

This Cal MediConnect Plan is offered by Blue Shield of California Promise Health Plan. When this *Member Handbook* says “we,” “us,” or “our,” it means Blue Shield of California Promise Health Plan. When it says “the plan” or “our plan,” it means Blue Shield Promise Cal MediConnect Plan.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

Español (Spanish): ATENCIÓN: Si usted habla español, hay a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-855-905-3825 (TTY: 711), de 8:00 a.m. a 8:00 p.m., los siete días de la semana. La llamada es gratuita.

繁體中文 (Chinese): 注意：如果您说中文，可以免费获得语言协助服务。请拨打1-855-905-3825（听障和语障专线：711），每周七天办公，早上8:00至晚上8:00。此电话为免付费专线。

Tiếng Việt (Vietnamese): LƯU Ý: Nếu quý vị nói tiếng Việt, chúng tôi sẽ cung cấp miễn phí dịch vụ hỗ trợ ngôn ngữ cho quý vị. Gọi số 1-855-905-3825 (TTY: 711), 8 giờ sáng đến 8 giờ tối, bảy ngày trong tuần. Cuộc gọi này miễn phí.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita kayo ng Tagalog, may mga available na libreng serbisyo ng tulong sa wika para sa inyo. Tumawag sa 1-855-905-3825 (TTY: 711), 8:00 a.m. hanggang 8:00 p.m., pitong araw sa isang linggo. Libre ang tawag.

한국어 (Korean): 주: 귀하가 한국어를 사용하시는 경우, 무료로 언어 지원 서비스를 이용하실 수 있습니다. 1-855-905-3825(TTY: 711)번으로 주 7일, 오전 8시부터 오후 8시까지 전화하실 수 있습니다. 이 전화는 무료입니다.

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, Ձեզ տրամադրվի են անվճար լեզվական օգնության ծառայություններ: Զանգահարեք 1-855-905-3825 (TTY՝ 711) համարով, 8:00-ից 20:00, շաբաթը յոթ օր: Հեռախոսազանգն անվճար է:

If you have questions, please call Blue Shield of California Promise Health Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information,** visit www.blueshieldca.com/promise/calmediconnect.



فارسی (Farsi):

توجه: اگر به زبان فارسی صحبت می کنید، خدمات امداد زبانی بدون اخذ هزینه در اختیار شما می باشد. با شماره 1-855-905-3825 (TTY: 711)، از ساعت 8:00 صبح تا 8:00 شب در هفت روز هفته تماس بگیرید. این تماس رایگان است.

Русский (Russian): ОБРАТИТЕ ВНИМАНИЕ! Если Вы говорите по-русски, мы можем предложить Вам бесплатные услуги языковой поддержки. Звоните по телефону 1-855-905-3825 (TTY: 711) с 8:00 до 20:00 без выходных. Звонок бесплатный.

日本語 (Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-905-3825 (TTY: 711) まで、お電話にてご連絡ください。毎日午前8時から午後8時まで受け付けています。通話は無料です。

العربية (Arabic):

تنبيه: إذا كنت تتحدث اللغة العربية، يتوفر لك خدمات المساعدة اللغوية المجانية. اتصل على الرقم 1-855-905-3825 (TTY: 711)، من الساعة 8:00 صباحًا إلى 8:00 مساءً طوال أيام الأسبوع. علمًا بأن هذه المكالمات مجانية.

ਪੰਜਾਬੀ (Punjabi): ਸਾਵਧਾਨ : ਜੇ ਤੁਸੀਂ [ਪੰਜਾਬੀ] ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਉਪਲਬਧ ਹਨ | ਕਾਲ ਕਰੋ 1-855-905-3825 (TTY: 711), ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8:00 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ ਸੱਤ ਦਿਨ | 711), ਸਵੇਰ ਦੇ 8 ਵਜੇ ਤੋਂ ਲੈ ਕੇ ਰਾਤ ਦੇ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ ਸੱਤ ਦਿਨ. ਕਾਲ ਫ੍ਰੀ ਹੈ |

ខ្មែរ (Cambodian/Khmer): ចាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសា គឺមានសំរាប់អ្នកដោយឥតគិតថ្លៃ។ ហៅ 1-855-905-3825 (TTY: 711) ម៉ោង 8:00 ព្រឹក ដល់ 8:00 យប់ ជ្រាបពីរដ្ឋប្បវេណី។ ហៅគឺឥតគិតថ្លៃ។

Hmoob (Hmong): LUS CEEV: Yog koj hais Lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-855-905-3825 (TTY: 711), 8:00 teev sawv ntxov txog 8:00 teev tsaus ntuj, xya hnuv hauv ib lub as thiv. Qhov hu xov tooj no yog hu dawb xwb.

हिंदी (Hindi): ध्यान: यदि आप भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। फोन करना 1-855-905-3825 (TTY: 711), सुबह 8:00 बजे से शाम 8:00 बजे तक, सप्ताह के सातों दिन। फोन करना फ्री है।

ภาษาไทย (Thai): เรียน หากคุณพูดภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยไม่มีค่าใช้จ่าย โทร 1-855-905-3825 (TTY: 711) 8:00 น. ถึง 20:00 น. ได้ตลอดเจ็ดวันต่อสัปดาห์ โทรฟรี ไม่มีค่าใช้จ่าย

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (Urdu): 1-855-905-3825 (TTY: 711).

ລາວ (Laotian): ສິ່ງສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວແມ່ນມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທຫາເບີ 1-855-905-3825 (TTY: 711), 8:00 ໂມງເຊົ້າ ຫາ 8:00 ໂມງແລງ, ເຈັດວັນຕໍ່ອາທິດ. ການໂທແມ່ນບໍ່ເສຍຄ່າ.

Українська (Ukrainian): ЗВЕРНІТЬ УВАГУ! Якщо Ви розмовляєте українською, ми можемо запропонувати Вам безкоштовні послуги мовної підтримки. Телефонуйте 1-855-905-3825 (TTY: 711) з 8:00 до 20:00 без вихідних. Дзвінок безкоштовний.

Mienh (Mien): TOV JANGX LONGX OC: Beiv taix meih gorngv Mienh waac nor, ninh mbuo gorn zangc duqv mbenc nzoih wang-henh nzie weih faan waac bun meih muangx maiv zuqc feix liuc cuotv zinh nyaanh. Douc waac lorx taux 1-855-905-3825 (TTY: 711), 8:00 diemv ziangh hoc lung

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.

ndorm mingh taux 8:00 ziangh hoc lungn muonz, yietc norm liv baaiz se koi nzoih siec hnoi. Naaiv norm douc waac gorn se wang-henh longc maiv zuqc feix liuc cuotv zinh nyaanh.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

- You can make a standing request to get this document in a language other than English or in an alternate format now and in the future. To make a request, please contact Blue Shield Promise Cal MediConnect Plan Customer Care will keep your preferred language and format on file for future communications. To make any updates on your preference, please contact Blue Shield Promise Cal MediConnect Plan.

2022 Member Handbook - Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Table of Contents

Chapter 1: Getting started as a member.	5
Chapter 2: Important phone numbers and resources.	16
Chapter 3: Using the plans coverage for your health care and other covered services.....	37
Chapter 4: Benefit Chart.	56
Chapter 5: Getting your outpatient prescription drugs through the plan.	111
Chapter 6: What you pay for your Medicare and Medi-Cal prescription drugs.	128
Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs.....	140
Chapter 8: Your rights and responsibilities.	145
Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints).	163
Chapter 10: Ending your membership in our Cal MediConnect plan.	212
Chapter 11: Legal notices.	221
Chapter 12: Definitions and important words.....	226

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

Disclaimers

- ❖ Blue Shield of California Promise Health Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
- ❖ Coverage under Blue Shield of California Promise Health Plan is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Blue Shield Promise Cal MediConnect Plan, a health plan that covers all 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 Blue Shield Promise Cal MediConnect Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Welcome to Blue Shield Promise Cal MediConnect Plan	7
B. Information about Medicare and Medi-Cal	7
B1. Medicare	7
B2. Medi-Cal	7
C. Advantages of this plan	8
D. Blue Shield Promise Cal MediConnect Plan’s service area	8
E. What makes you eligible to be a plan member	9
F. What to expect when you first join a health plan	9
G. Your Care Team and Care Plan	10
G1. Care Team.....	10
G2. Care Plan	11

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.



H. Blue Shield Promise Cal MediConnect Plan monthly plan premium	11
I. The <i>Member Handbook</i>	11
J. Other information you will get from us	11
J1. Your Blue Shield Promise Cal MediConnect Plan Member ID Card.....	11
J2. <i>Provider and Pharmacy Directory</i>	12
J3. <i>List of Covered Drugs</i>	13
J4. The <i>Explanation of Benefits</i>	14
K. How to keep your membership record up to date	14
K1. Privacy of personal health information (PHI)	15

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

A. Welcome to Blue Shield Promise Cal MediConnect Plan

Blue Shield Promise Cal MediConnect Plan is a Cal MediConnect Plan. A Cal MediConnect Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. It also has care navigator and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Blue Shield Promise Cal MediConnect Plan was approved by the State of California and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Cal MediConnect.

Cal MediConnect is a demonstration program jointly monitored by California and the federal government to provide better care for people who have both Medicare and Medi-Cal. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medi-Cal services.

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

- People 65 years of age or older,
- Some people under age 65 with certain disabilities, **and**
- People with end-stage renal disease (kidney failure).

B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources 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 qualifies,
- 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 California approved Blue Shield Promise Cal MediConnect Plan. You can get Medicare and Medi-Cal services through our plan as long as:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.



- 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 will not be affected.

C. Advantages of this plan

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

Blue Shield Promise Cal MediConnect Plan will help make your Medicare and Medi-Cal benefits work better together and work better for you. Some of the advantages include:

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will 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 will have access to a care navigator. This is a person who works with you, with Blue Shield Promise Cal MediConnect Plan, and with your care team to help make a care plan.
- You will be able to direct your own care with help from your care team and care navigator.
- The care team and care navigator will work with you to come up with a care plan specifically designed to meet your health needs. The care team will help coordinate the services you need. This means, for example:
 - Your care team will make sure your doctors know about all the medicines you take so they can make sure you are taking the right medicines, and so your doctors can reduce any side effects you may have from the medicines.
 - Your care team will make sure your test results are shared with all your doctors and other providers, as appropriate.

D. Blue Shield Promise Cal MediConnect Plan's service area

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

Only people who live in our service area can join Blue Shield Promise Cal MediConnect Plan.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8 for more information about the effects of moving out of our service area. You will need to contact your local county eligibility worker:

Los Angeles County Department of Public Social Services (DPSS) Customer Service Center	CALL: 1-866-613-3777 This call is free. TTY: 711 Hours: 7:30 a.m. – 5:30 p.m., Monday through Friday, excluding holidays
---	--

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, **and**
- Are age 21 and older at the time of enrollment, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- Are currently eligible for Medi-Cal **and**
- Are a United States citizen or are lawfully present in the United States.

There may be additional eligibility rules in your county. Call Customer Care for more information.

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

When you first join the plan, you will get a health risk assessment (HRA) within the first 45-90 days.

We are required to complete an HRA for you. This HRA is the basis for developing your individual care plan (ICP). The HRA will include questions to identify your medical, LTSS, and behavioral health and functional needs.

We will reach out to you to complete the HRA. The HRA can be completed by an in-person visit, telephone call, or mail.

We will send you more information regarding this HRA.

If Blue Shield Promise Cal MediConnect Plan is new for you, you can keep using the doctors you use now for a certain amount of time. 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 makes a direct request to us to continue to use your current provider.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.



- We can 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 Blue Shield Promise Cal MediConnect Plan.
 - We will determine an existing relationship by reviewing your health information available to us or information you give us.
 - We have 30 days to respond to your request. You may also ask us to make a faster decision and we must respond in 15 days.
 - We have 3 calendar days to respond if there is a risk you will be harmed due to an interruption in your care.
 - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: This request **cannot** be made for providers of Durable Medical Equipment (DME), transportation, other ancillary services, or services not included under Cal MediConnect.

After the continuity of care period ends, you will need to use doctors and other providers in the Blue Shield Promise Cal MediConnect Plan 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. A medical group or an Independent Physician Association (IPA) is an organization formed under California law that contracted with health plans to provide or arrange for the provisions of health care services to health plan enrollees. A medical group or IPA is an association of primary care physicians and specialists created to provide coordinated health care services to you. Refer to Chapter 3 for more information on getting care.

G. Your Care Team and Care Plan

G1. Care Team

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

A care navigator is a person who is trained to help you manage the care you need. You will get a care navigator when you enroll in Blue Shield Promise Cal MediConnect Plan. This person will also refer you to community resources, if Blue Shield Promise Cal MediConnect Plan does not provide the services that you need.

You can call us at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week to ask for a care team. The call is free.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

G2. Care Plan

Your care team will work with you to come up with a care plan. A care plan tells you and your doctors what services you need, and how you will get them. It includes your medical, behavioral health, and LTSS needs. Your care plan will be made just for you and your needs.

Your care plan will include:

- Your health care goals.
- A timeline for when you should get the services you need.

After your health risk assessment, your care team will meet with you. They will talk to you about services you need. They can also tell you about services you may want to think about getting. Your care plan will be based on your needs. Your care team will work with you to update your care plan at least every year.

H. Blue Shield Promise Cal MediConnect Plan monthly plan premium

Blue Shield Promise Cal MediConnect Plan does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, refer to Chapter 9 Section D, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. You can also refer to the *Member Handbook* at www.blueshieldca.com/promise/calmediconnect or download it from this website.

The contract is in effect for the months you are enrolled in Blue Shield Promise Cal MediConnect Plan between January 01, 2022 and December 31, 2022.

J. Other information you will get from us

You should have already gotten a Blue Shield Promise Cal MediConnect Plan Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs*.

J1. Your Blue Shield Promise Cal MediConnect Plan Member ID Card

Under our plan, you will have one card for your Medicare and Medi-Cal services, including long-term services and supports, certain behavioral health services, and prescriptions. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.



 Promise Health Plan	PLAN NAME LINE 2 LINE 3
Member Name: MEMBER NAME LINE 1 MEMBER NAME LINE 2 Member ID: AMPJ12345678	Effective Date: 01/01/2020 MEMBER CANNOT BE CHARGED PCP/SPC/ER: \$0/\$0/\$0
PCP: PCP NAME LINE 1 PCP NAME LINE 2 PCP NAME LINE 3 PCP Ph: (555) 123-4567	RxBIN: RXBIN RxPCN: RXPCN CMS ID: H0148-PBP
IPA NAME LA LINE 1 IPA NAME LA LINE 2	

Website: www.blueshieldca.com/promise
Customer Care (855) 905-3825 (TTY: 711)
Nurse Help Line (800) 609-4166
Transportation (877) 433-2178
Pharmacy Help Desk (888) 970-0933
Behavioral Health (855) 765-9701 (TTY: 711)
Submit Rx Claims to: **Submit Medical Claims to:**
 Blue Shield of California Blue Shield of California Promise
 P.O. Box 52066 Health Plan P.O. Box 272660
 Phoenix, AZ 85072 Chico, CA 95927
This member has limited benefits outside of the plan service area and outside of California. Members with emergency claims should call 911 or go to the nearest ER. Providers should bill claims with your local CBS license in whose service area the member received services. CA Providers: Most claims should be filed with the member's IPA/Medical Group. Call Provider Customer Service to obtain medical and hospital admission prior authorization to avoid reduced or non-payment. Pharmacists call for prescription processing information. Visit Provider connection at: blueshieldca.com/provider
 Blue Shield of California Promise Health Plan is an independent licensee of the Blue Shield Association.

If your Cal MediConnect card is damaged, lost, or stolen, call Customer Care right away and we will send you a new card. You can call Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

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 Cal MediConnect services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Blue Shield Promise Cal MediConnect Plan Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 Section A to find out what to do if you get a bill from a provider.

Please remember, for the specialty mental health services that you may get from the county mental health plan (MHP), you will need your Medi-Cal card to access those services.

J2. Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Blue Shield Promise Cal MediConnect Plan network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (refer to page 40).

You can ask for a *Provider and Pharmacy Directory* by calling Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. You can also refer to the *Provider and Pharmacy Directory* at www.blueshieldca.com/promise/calmediconnect or download it from this website.

The *Provider and Pharmacy Directory* lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support Providers (such as Adult Day Health and Home Health Providers) that you may see as a Blue Shield Promise Cal MediConnect Plan Member. The Directory lists the pharmacies that you may use to get your prescription drugs. The Directory also provides some information on the following:

- When referrals are needed to see other Providers, specialists or facilities, and
- How to choose a doctor, and
- How to change your doctor, and

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

For more information, visit www.blueshieldca.com/promise/calmediconnect.



- How to find doctors, specialists, pharmacies, or facilities in your area and/or medical group/IPA, and
- How to access Long-Term Services and Supports (LTSS), In-Home Supportive Services (IHSS) or Multipurpose Senior Services Programs (MSSP), and
- Information on how to access mail service order, home infusion or long-term care pharmacies.

Definition of network providers

- Blue Shield Promise Cal MediConnect Plan's network providers include:
 - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
 - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
 - LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them.

Call Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week for more information. Both Customer Care and Blue Shield Promise Cal MediConnect Plan's 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 are covered by Blue Shield Promise Cal MediConnect Plan.

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 Section C for more information on these rules and restrictions.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

Each year, we will 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, visit www.blueshieldca.com/promise/calmediconnect or call 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. Chapter 6 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

K. How to keep your membership record up to date

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

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you.** Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.
- Admission to a nursing home or hospital.
- Care in a hospital or emergency room.
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study.

If any information changes, please let us know by calling Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.



For more information, visit www.blueshieldca.com/promise/calmediconnect.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). State and federal laws require that we keep your PHI private. We make sure that your PHI is protected. For more details about how we protect your PHI, refer to Chapter 8 Section C.



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 Blue Shield Promise Cal MediConnect Plan and your health care benefits. You can also use this chapter to get information about how to contact your care navigator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. How to contact Blue Shield Promise Cal MediConnect Plan Customer Care	18
A1. When to contact Customer Care	18
B. How to contact your Care Navigator	21
B1. When to contact your care navigator	21
C. How to contact the Nurse Advice Call Line	23
C1. When to contact the Nurse Advice Call Line	23
D. How to contact the Behavioral Health Crisis Line	24
D1. When to contact the Behavioral Health Crisis Line	24
E. How to contact the Health Insurance Counseling and Advocacy Program (HICAP)	26
E1. When to contact HICAP	26
F. How to contact the Quality Improvement Organization (QIO)	27
F1. When to contact Livanta Beneficiary and Family Care Quality Improvement Organization (BFCC-QIO)	27
G. How to contact Medicare	28
H. How to contact Medi-Cal Health Care Options	29
I. How to contact the Cal MediConnect Ombuds Program	30
J. How to contact County Social Services	31
K. How to contact your County Specialty Mental Health Plan	32

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



K1. Contact the county specialty mental health plan about:.....	32
L. How to contact the California Department of Managed Health Care	33
M. Other resources.....	34



A. How to contact Blue Shield Promise Cal MediConnect Plan Customer Care

Contact type	
CALL	<p>1-855-905-3825 This call is free.</p> <p>8:00 a.m. to 8:00 p.m., seven days a week</p> <p>You can get this document for free in other formats, such as large print, Braille and/or audio by calling the number above.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>8:00 a.m. to 8:00 p.m., seven days a week.</p>
WRITE	<p>Blue Shield of California Promise Health Plan Customer Care Department 601 Potrero Grande Dr. Monterey Park, CA 91755</p>
WEBSITE	<p>www.blueshieldca.com/promise/calmediconnect</p>

A1. When to contact Customer Care

- Questions about the plan
- Questions about claims, billing or Member ID Cards
- 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 will 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 Section D.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- 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.
 - To learn more about making an appeal, refer to Chapter 9 Section D.
- 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 the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to Section F below).
 - You can call us and explain your complaint. Call Customer Care at 1-855-905-3825 (TTY: 711) 8:00 a.m. to 8:00 p.m., seven days a week.
 - 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 Blue Shield Promise Cal MediConnect 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 Blue Shield Promise Cal MediConnect Plan to the Cal MediConnect Ombuds Program by calling 1-855-501-3077 (TTY: 1-855-847-7914) Monday through Friday, 9:00 a.m. to 5:00 p.m.
 - To learn more about making a complaint about your health care, refer to Chapter 9 Section J.
- Coverage decisions about your drugs
 - A coverage decision about your drugs is a decision about:
 - Your benefits and covered drugs, **or**
 - The amount we will pay for your drugs.
 - This applies to your Part D drugs, Medi-Cal prescription drugs, and Medi-Cal over-the-counter drugs.
 - For more on coverage decisions about your prescription drugs, refer to Chapter 9 Section F.
- Appeals about your drugs



- An appeal is a way to ask us to change a coverage decision.
- To make an appeal on a coverage decision for any of your drugs that are on the Blue Shield Promise Cal MediConnect Plan *List of Covered Drugs* (Formulary), contact Customer Care at 1-855-905-3825 (TTY: 711) 8:00 a.m. to 8:00 p.m., seven days a week. Medi-Cal drugs are labeled with an asterisk (*) in the Formulary.
- For more on making an appeal about your prescription drugs, refer to Chapter 9 Section J.
- 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 Blue Shield Promise Cal MediConnect 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. TTY/TTD users can call 1-877-486-2048.
 - For more on making a complaint about your prescription drugs, refer to Chapter 9 Section J.
- 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 Section A.
 - 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 Section D2 for more on appeals.



B. How to contact your Care Navigator

A Care Navigator is a person specially trained to help you through the coordination of care process. Your Care Navigator will be part of your Care Team, and he/she will serve as a primary source of contact for you. You will be assigned a Care Navigator when you enroll in the health plan. The Care Navigator will call you to introduce him/her and help identify your needs. You can contact your Care Navigator by calling Blue Shield Promise Cal MediConnect Plan Customer Care and selecting the Care Navigator option in the queue. Once a Care Navigator is assigned to you, you can also contact him/her by calling their direct phone line. To request to change your Care Navigator, you may call Blue Shield Promise Cal MediConnect Plan Customer Care.

<small>Contact Type</small> CALL	1-855-905-3825 This call is free. 8:00 a.m. to 8:00 p.m., seven days a week You can get this document for free in other formats such as large print, Braille and/or audio by calling the number above. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 8:00 a.m. to 8:00 p.m., seven days a week
WRITE	Blue Shield of California Promise Health Plan Customer Care Department 601 Potrero Grande Dr. Monterey Park, CA 91755
WEBSITE	www.blueshieldca.com/promise/calmediconnect

B1. When to contact your care navigator

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about transportation
- Questions about long-term services and supports (LTSS)

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



LTSS include Community-Based Adult Services (CBAS) and Nursing Facilities (NF).

Long-Term Services and Supports (LTSS) refers to a wide range of services that support adults with functional impairments and /or chronic illnesses to live independently in the community or in a long-term care facility. LTSS are for members who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. If you need assistance to continue to live independently, please call Customer Care for a referral.

LTSS includes: Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), Long-Term Care/Custodial Care.

Sometimes you can get help with your daily health care and living needs.

You might be able to get these services:

- Community-Based Adult Services (CBAS),
- Skilled nursing care,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services, **and**
- Home health care.



C. How to contact the Nurse Advice Call Line

Blue Shield of California Promise Health Plan Nurse Advice Line offers support with registered nurses available to answer questions 24 hours a day, 7 days a week. Call the Nurse Advice Line at (800) 609-4166 (TTY: 711). Nurses are available via phone to respond to general health questions and provide direction to additional resources for more information. With the Nurse Advice Line, members can have a summary of the conversation emailed to them which includes all the information and links for easy reference.

Contact Type	
CALL	<p>(800) 609-4166 This call is free.</p> <p>24 hours a day, seven days a week</p> <p>You can get this document for free in other formats, such as large print, Braille and/or audio by calling the number above.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, seven days a week.</p>

C1. When to contact the Nurse Advice Call Line

- Questions about your health care

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



D. How to contact the Behavioral Health Crisis Line

<small>Contact Type</small> CALL	<p>Los Angeles Access and Crisis Line</p> <p>1-800-854-7771 This call is free.</p> <p>24 hours a day, seven days a week.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, seven days a week</p>
Call	<p>Blue Shield of California Promise Health Plan Managed Behavioral Health Organization</p> <p>1-855-765-9701 This call is free</p> <p>24 hours a day, seven days a week.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, seven days a week</p>

D1. When to contact the Behavioral Health Crisis Line

- Questions about behavioral health and substance abuse services
- When experiencing a Mental Health Crisis call the Los Angeles Access Crisis line available 24 hours a day, seven days a week. The contact information is available above.
- When you have questions about mental health and substance abuse disorder services, contact Blue Shield of California Promise Health Plan Behavioral Health Services. The contact information is available above.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Cal MediConnect health plans are responsible for providing enrollees access to all medically necessary behavioral health (mental health and substance use treatment) services currently covered by Medicare and Medi-Cal.

For questions regarding your county specialty mental health services, refer to page 32.



E. How to contact the Health Insurance Counseling and Advocacy Program (HICAP)

The Health Insurance Counseling and Advocacy Program (HICAP) gives free health insurance counseling to people with Medicare. HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is not connected with any insurance company or health plan.

<small>Contact Type</small> CALL	Center for Health Care Rights 1-213-383-4519 Monday through Friday, 8:30 a.m. to 4:30 p.m.
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 HICAP Office 520 S. Lafayette Park Place, Suite 214 Los Angeles, CA 90057
WEBSITE	https://www.aging.ca.gov/HICAP

E1. When to contact HICAP

- Questions about your Cal MediConnect plan or other Medicare questions
 - 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.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called a Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta BFCC-QIO is not connected with our plan.

<small>Contact Type</small> CALL	1-877-588-1123
TTY	1-855-887-6668 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	https://www.livantaqio.com/en

F1. When to contact Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)

- Questions about your health care
 - You can make a complaint about the care you got if you:
 - have a problem with the quality of care,
 - think your hospital stay is ending too soon, **or**
 - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

<small>Contact Type</small> CALL	<p>1-800-MEDICARE (1-800-633-4227)</p> <p>Calls to this number are free, 24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p>
WEBSITE	<p><u>www.medicare.gov</u></p> <p>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.</p> <p>It includes helpful websites and phone numbers. It also has booklets you can print right from your computer.</p> <p>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, print it out, and send it to you.</p>

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



H. How to contact Medi-Cal Health Care Options

Medi-Cal Health Care Options can help you if you have questions about selecting a Cal MediConnect plan or other enrollment issues.

<small>Contact Type</small> CALL	1-844-580-7272 Health Care Options representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday.
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	California Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



I. How to contact the Cal MediConnect Ombuds Program

The Cal MediConnect Ombuds Program 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 Cal MediConnect Ombuds Program can also help you with service or billing problems. The Cal MediConnect Ombuds Program is not connected with our plan or with any insurance company or health plan. Their services are free.

<small>Contact Type</small> CALL	1-855-501-3077 This call is free. Monday through Friday, 9:00 a.m. to 5:00 p.m.
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	<u>Neighborhood Legal Services of Los Angeles County</u> <ul style="list-style-type: none"> • 13327 Van Nuys Boulevard Pacoima, CA 91131 • 1104 E. Chevy Chase Drive Glendale, CA 91205 • 3629 Santa Anita Avenue El Monte, CA 91731
WEBSITE	www.healthconsumer.org

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



J. How to contact County Social Services

If you need help with your Los Angeles County health and social service benefits, contact your local County Social Services Department.

<small>Contact Type</small> CALL	<p>1-866-613-3777 This call is free.</p> <p>Los Angeles County Department of Public Social Services has a Customer Service Center (CSC) serving 33 District Offices. Hours of operation are Monday through Friday, excluding holidays, from 7:30 a.m. until 5:30 p.m.</p>
TTY	<p>1-877-735-2929</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p>
WRITE	<p>Los Angeles County Department of Public Social Services 2855 E. Olympic Blvd. Los Angeles, CA 90023</p>
WEBSITE	<p>https://dpss.lacounty.gov</p>

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



K. How to contact your County Specialty Mental Health Plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet the medical necessity criteria.

<small>Contact Type</small> CALL	<p>1-800-854-7771 This call is free.</p> <p>24 hours a day, seven days a week. You can get this document for free in other formats, such as large print, Braille and/or audio by calling the number above.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, seven days a week.</p>

K1. Contact the county specialty mental health plan about:

- Questions about behavioral health services provide by the county
- Specialty mental health services including but not limited to:
 - Outpatient mental health services
 - Day treatment
 - Crisis intervention and stabilization
 - Targeted case management
 - Adult residential treatment
 - Crisis residential treatment

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



L. How to contact the 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 against your health plan 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.dmhca.ca.gov

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



M. Other resources

How to contact the Los Angeles County Area Agency on Aging

AIS provides services to older adults, people with disabilities and their family members, to help keep them safely in their homes, promote healthy and vital living, and publicize positive contributions made by older adults and persons with disabilities.

CALL	1-888-202-4248 Monday through Friday, 8:00 a.m. to 5:00 p.m.
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 Workforce Development, Aging and Community Services 3175 W. 6 th St. Los Angeles, CA 90020
WEBSITE	https://css.lacounty.gov/

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



How to contact the Los Angeles County Regional Centers

Regional centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California to provide local resources to help find and access the many services available to individuals and their families. California has 21 regional centers with more than 40 offices located throughout the state that serve individuals with developmental disabilities and their families. To access the Directory of Regional Centers, go to the website listed below.

CALL	1-916-654-1690 Monday through Friday, 8:00 a.m. to 5:00 p.m.
TTY	1-916-654-2054 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	1600 9 th Street P.O. Box 944202 Sacramento, CA 94244-2020
WEBSITE	www.dds.ca.gov

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



How to contact the Neighborhood Legal Services of Los Angeles County

The Neighborhood Legal Services of Los Angeles County (NLSLA), provides free legal services to those in need. NLSLA can assist people with different legal issues including housing, family law, economic security, access to justice, health insurance and more.

CALL	1-800-433-6251 Monday, Wednesday and Friday, 9:00 a.m. to 1:00 p.m.
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	<u>Neighborhood Legal Services of Los Angeles County</u> 13327 Van Nuys Boulevard Pacoima, CA 91131 1104 E. Chevy Chase Drive Glendale, CA 91205 3629 Santa Anita Avenue El Monte, CA 91731
WEBSITE	www.nlsla.org

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Chapter 3: Using the 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 Blue Shield Promise Cal MediConnect Plan. It also tells you about your care navigator, 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 when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about “services,” “covered services,” “providers,” and “network providers”	39
B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan	39
C. Information about your care navigator	41
C1. What a care navigator is	41
C2. How you can contact your care navigator	41
C3. How you can change your care navigator	41
D. Care from primary care providers, specialists, other network medical providers, and out-of-network medical providers	41
D1. Care from a primary care provider	41
D2. Care from specialists and other network providers	44
D3. What to do when a provider leaves our plan	44
D4. How to get care from out-of-network providers	45
E. How to get long-term services and supports (LTSS)	45
F. How to get behavioral health (mental health and substance use disorder) services	46
F1. What Medi-Cal behavioral health services are provided outside of Blue Shield Promise Cal MediConnect Plan through Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH)?	46

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m, seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



G. How to get transportation services.....	48
H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster	48
H1. Care when you have a medical emergency.....	48
H2. Urgently needed care.....	50
H3. Care during a disaster.....	50
I. What to do if you are billed directly for services covered by our plan	51
I1. What to do if services are not covered by our plan	51
J. Coverage of health care services when you are in a clinical research study	51
J1. Definition of a clinical research study	51
J2. Payment for services when you are in a clinical research study.....	52
J3. Learning more about clinical research studies	52
K. How your health care services are covered when you get care in a religious non-medical health care institution.....	52
K1. Definition of a religious non-medical health care institution	52
K2. Getting care from a religious non-medical health care institution.....	53
L. Durable medical equipment (DME).....	53
L1. DME as a member of our plan	53
L2. DME ownership when you switch to Original Medicare or Medicare Advantage	54
L3. Oxygen equipment benefits as a member of our plan.....	54
L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage.....	55



A. Information about “services,” “covered services,” “providers,” and “network providers”

Services are health care, long-term services and supports, 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 long-term services and supports (LTSS) are listed in the Benefits Chart in Chapter 4 Section D.

Providers are doctors, nurses, and other people who give you services and care. The term providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain long-term services and supports (LTSS).

Network providers are providers who work with the health plan. These providers have agreed 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 your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

Blue Shield Promise Cal MediConnect Plan covers all services covered by Medicare and Medi-Cal. This includes behavioral health and long-term services and supports (LTSS).

Blue Shield Promise Cal MediConnect Plan will generally pay for the health care services, behavioral health services, and LTSS you get if you follow the plan's rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 Section D of this handbook).
- The care must be determined **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your 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.
- For medical services, you must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
 - In most cases, our plan must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Blue Shield Promise Cal MediConnect Plan may not cover the services. You don't need a referral to use certain specialists,

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



such as women's health specialists. To learn more about referrals, refer to page 43.

- 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 will be referring you to specialists and services that are also affiliated with their medical group. A medical group is an association of primary care physicians 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 or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 43.
- To learn more about choosing a PCP, refer to page 42.
- **You must get your care from network providers that are affiliated with your PCP's medical group.** Usually, the plan will not cover care from a provider who does not work with the health plan and your PCP's medical group. Here are some cases when this rule does not apply:
 - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to find out what emergency or urgently needed care is, refer to Section H, page 48.
 - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. An authorization is needed and should be obtained from the plan prior to seeking care. In this situation, we will cover the care as if you got it from a network provider **or** at no cost to you. To learn about getting approval for an out-of-network provider, refer to Section D, page 41.
 - The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
 - When you first join the plan, you can ask to continue to use your current providers. With some exceptions, we are required to approve this request if we can establish that you had an existing relationship with the providers (refer to Chapter 1, page 10). 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 navigator 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.



C. Information about your care navigator

C1. What a care navigator is

A care navigator is a person specially trained to help you through the coordination of care process. Your care navigator will be part of your care team and he/she will serve as a primary source of information/contact for you. You will be assigned a care navigator when you enroll in Blue Shield Promise Cal MediConnect Plan. The care navigator will call you to introduce him/her and help identify your needs.

C2. How you can contact your care navigator

You can contact your care navigator by calling Blue Shield Promise Cal MediConnect Plan Customer Care and selecting the care navigator option in the queue. Once a care navigator is assigned to you, you can also contact him/her by calling their direct phone line.

C3. How you can change your care navigator

To request to change your care navigator, you may call Blue Shield Promise Cal MediConnect Plan Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 pm., seven days a week.

D. Care from primary care providers, specialists, other network medical providers, and out-of-network medical providers

D1. Care from a primary care provider

You must choose a primary care provider (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

Your PCP is a physician who meets state requirements and is trained to give you basic medical care. A PCP can be a Family Practitioner, General Practitioner, Internal Medicine Provider, and a specialist upon request. You may choose a specialist as your PCP if the specialist agrees to provide all the services that PCPs traditionally provide. To request for your specialist to be your PCP, contact Blue Shield Promise Cal MediConnect Plan Customer Care (phone numbers and hours of operation are printed on the bottom of this page). A clinic, such as Federally Qualified Health Centers (FQHC), may be your PCP as well. You will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you need. These covered services include:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Hospital admissions, and
- Follow-up care

Our plan's PCPs are affiliated with particular medical groups. Medical group or an independent physician association (IPA) is an organization formed under California law that contracts with health plans to provide or arrange for the provisions of health care services to health plan enrollees. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP will be referring you to specialists and services that are also affiliated with his or her medical group.

In most cases, you must see your PCP to get a referral before you see any other health care Providers or visit a specialist. You may self-refer to an obstetrical and gynecological (OBGYN) specialist within your contracting medical group or IPA for a routine Pap smear, pelvic exam and breast exam annually. Once this referral is approved by your PCP's medical group, you can make an appointment with the specialist or other Provider to receive the treatment you need. The specialist will inform your PCP upon completion of your treatment or service so your PCP can continue to manage your care.

In order for you to receive certain services, your PCP will need to get approval in advance from the Plan, or, in some cases, your PCP's affiliated medical group. This approval in advance is called "prior authorization."

Your choice of PCP

When you become a member of our plan, you must choose a plan Provider to be your PCP.

To choose your PCP, you can:

- Use your Provider & Pharmacy Directory. Look in the index of "Primary Care

Physicians" located in the back of the directory to find the doctor you want. (The index is in alphabetical order by the doctors' last names.); or

- Go to our website at www.bluehshieldca.com/promise/calmediconnect and search for the PCP you want; or
- Call Blue Shield Promise Cal MediConnect Plan Customer Care for help (phone number and hours of operation are printed on the bottom of this page).

To find out if the health care Provider you want is available or accepting new patients, refer to the *Provider & Pharmacy Directory* available on our website at www.bluehshieldca.com/promise/calmediconnect, or call Customer Care (phone number and hours of operation are printed on the bottom of this page).

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



If there is a particular Blue Shield Promise Cal MediConnect Plan specialist or hospital that you want to use, it is important to see whether they are affiliated with your PCP's medical group. You can look in the *Provider and Pharmacy Directory* available on our website at www.blueshieldca.com/promise/calmediconnect, or ask Blue Shield Promise Cal MediConnect Plan Customer Care to check to see 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 plan network, we can help you find a new PCP who is within our plan network if the one you now have leaves our network.

You can follow the steps in "Your choice of PCP" above in order to change your PCP. Make sure you call Customer Care to let them know you are changing your PCP (phone number and hours of operation are printed at the bottom of this page).

Once your change has been requested, the assignment to the new PCP and his or her affiliated Medical Group will occur on the first day of the next month following your request to change your PCP.

The name and office telephone number of your PCP is printed on your membership card. If you change your PCP, you will receive a new membership card.

Remember, 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 the change, be sure to tell Customer Care whether you are using a specialist or getting other covered services that require PCP approval. Customer Care will help make sure that you can continue your specialty care and other services when you change your PCP.

Services you can get without first getting approval from your PCP

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

- 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 network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Customer Care before you leave the service area. We can help you get dialysis while you are 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 eligible to get services from Indian health providers, you may use these providers without a referral.

D2. Care from specialists and other network providers

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

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

When you need specialty care or additional services your PCP cannot provide, he or she will give you a referral. Once this referral is approved by your PCP's medical group, you can make an appointment with the specialist or other Provider to receive the treatment you need. The specialist will inform your PCP upon completion of your treatment or service so your PCP can continue to manage your care.

Your PCP will need to get approval in advance from the Plan for you to receive certain services. This approval in advance is called "prior authorization." For example, prior authorization is required for all non-emergency inpatient hospital stays. In some cases, your PCP's affiliated medical group, instead of our plan, may be able to authorize your service.

If you have any questions about who is responsible for submitting and approving prior authorizations for services, contact your PCP's affiliated medical group. You can also call Customer Care. For more information about which services require prior authorization, please refer to the Benefits Chart in Chapter 4, Section D.

D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.



- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Please call Blue Shield Promise Cal MediConnect Plan Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

D4. How to get care from out-of-network providers

If you need medical care that Medicare and/or Medi-Cal requires our plan to cover and the Providers in our network cannot provide this care, you can get this care from an out-of-network Provider. Your Primary Care Physician is responsible for submitting the request for prior authorization for out-of-network services. You must obtain an authorization from the plan or your PCP's affiliated medical group prior to seeking care from an out-of-network Provider. In this situation, you will pay the same as you would pay if you got the care from a network Provider.

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. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) consist of Community Based Adult Services (CBAS) and Nursing Facilities (NF). The services may occur in your home, community, or in a facility. The different types of LTSS are described below:

- **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 if you meet applicable eligibility criteria.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- **Nursing Facility (NF):** A facility that provides care for people who cannot safely live at home but who do not need to be in the hospital.

Your care navigator will help you understand each program. To find out more about any of these programs, call Blue Shield Promise Cal MediConnect Plan Customer Care to get connected with a care navigator (phone numbers and hours of operation are printed at the bottom of this page).

F. How to get behavioral health (mental health and substance use disorder) services

You will have access to medically necessary behavioral health services that are covered by Medicare and Medi-Cal. Blue Shield Promise Cal MediConnect Plan provides access to behavioral health services covered by Medicare. Medi-Cal covered behavioral health services are not provided by Blue Shield Promise Cal MediConnect Plan, but will be available to eligible Blue Shield Promise Cal MediConnect Plan members through Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH).

F1. What Medi-Cal behavioral health services are provided outside of Blue Shield Promise Cal MediConnect Plan through Los Angeles County Department of Mental Health (LACDMH) and Los Angeles County Department of Public Health (LACDPH)?

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet Medi-Cal specialty mental health services medical necessity criteria. Medi-Cal specialty mental health services provided by Los Angeles County Department of Mental Health (LACDMH) include:

- Mental health services (assessment, therapy, rehabilitation, collateral, and plan development)
- 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

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Targeted case management

Drug Medi-Cal services are available to you through Los Angeles County Department of Public Health (LACDPH) if you meet the Drug Medi-Cal medical necessity criteria. Drug Medi-Cal services provided by Los Angeles County Department of Public Health (LACDPH) include:

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

In addition to the Drug Medi-Cal services listed above, you may have access to voluntary inpatient detoxification services if you meet the medical necessity criteria.

Availability of Behavioral Health Services

You have a comprehensive array of services available to you. You may self-refer to a contracted Provider, and can also be referred by your PCP, family member, etc. There is “no wrong door” in accessing services. You can contact the following for assistance in getting services:

- County Crisis and Referral Line (please see Chapter 2, Section K of this handbook for phone number and hours of operation)
- LA County Department of Public Health, Substance Abuse Prevention and Control (please call 888-742-7900 (TTY: 711), 24 hours, seven days a week)
- Blue Shield Promise Cal MediConnect Plan Behavioral Health Line (please see Chapter 2, Section D of this handbook for phone number and hours of operation)
- Blue Shield Promise Cal MediConnect Plan Customer Care (phone number and hours of operation are printed on the bottom of this page)

Process to Determine Medical Necessary Services

Medical necessity is determined by an appropriately licensed Provider. Medical necessity criteria are used by both Blue Shield Promise Cal MediConnect Plan and the County, have been developed by behavioral health experts and other stakeholders, and are consistent with regulatory requirements.

Referral Process between Blue Shield Promise Cal MediConnect Plan and the County

If you are receiving services from Blue Shield Promise Cal MediConnect Plan or the County, you can be referred to the other entity consistent with your needs. Blue Shield Promise Cal MediConnect Plan or the County can refer you by calling the entity to which the referral is being made. Also, a referral form will be completed by the referring Provider, and it will be sent to the entity that you are being referred to.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Problem Resolution Process

If there is a dispute between you, and the County or Blue Shield Promise Cal MediConnect Plan, you will continue to receive medically necessary behavioral healthcare, including prescription drugs, until the dispute is resolved. Blue Shield Promise Cal MediConnect Plan has worked with the county to develop resolution processes that are timely and do not negatively impact the services that you are in need of getting. You can also use the Appeals process of Blue Shield Promise Cal MediConnect Plan or the County, depending upon the entity that you are in dispute with.

G. How to get transportation services

Medical Transportation Services are emergency ambulance services. Emergency ambulance transportation to the first hospital which actually accepts the member for emergency care is covered in connection with emergency services. These services include ambulance and ambulance transportation services provided through the "911" emergency response system.

Non-Emergency Medical Transportation (NEMT) is covered under Blue Shield Promise Cal MediConnect Plan. NEMT services are appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. Transportation services may be provided via an ambulance, litter van, or wheelchair van medical transportation services. Transfer of a member from a hospital to another hospital or facility, or facility to home should be:

- Medically necessary, and
- Requested by a Plan Provider, and
- Authorized in advance by Blue Shield Promise Cal MediConnect Plan.

Blue Shield Promise Cal MediConnect Plan also offers **Non-Medical Transportation (NMT)** services to and from your doctor's office. Transportation services are provided via taxicab, passenger vehicle, or other forms. All members requesting transportation must be eligible for the services for the month the transportation is requested. Arrangements for Non-Emergency Medical Transportation and Non-Medical Transportation are handled by Blue Shield Promise Cal MediConnect Plan Customer Care Department. You may call Blue Shield Promise Cal MediConnect Plan Customer Care to get connected to the transportation division or call them directly at 1-877-433-2178 (TTY: 711), 24 hours and 7 days a week. It is strongly recommended that arrangements for travel be made at least twenty-four (24) hours in advance.

H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

H1. Care when you have a medical emergency

Definition of a medical emergency

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it does not 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.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to 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 will not have to pay for emergency services because of a delay in telling us. Call Blue Shield Promise Cal MediConnect Plan Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. Our Customer Care phone number is located on your membership ID card.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, refer to the Benefits Chart in Chapter 4 Section D.

In 2022, Blue Shield Promise Cal MediConnect Plan is offering our members emergency medical coverage whenever you need it, anywhere in the world. There is no plan coverage limit for emergency/urgent services outside the United States every year. To learn more, see the Benefits Chart in Chapter 4, Section D

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by us. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



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

However, after the doctor says it was not an emergency, we will cover your additional care only if:

- You go to a network provider, **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (Refer to the next section.)

H2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

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

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

Blue Shield Promise Cal MediConnect Plan is offering our members urgently needed medical coverage whenever you need it, anywhere in the world. There is no plan coverage limit for emergency/urgent services outside the United States every year. To learn more, see the Benefits Chart in Chapter 4, Section D

H3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Blue Shield Promise Cal MediConnect Plan.

Please visit our website for information on how to obtain needed care during a declared disaster: www.blueshieldca.com/promise/calmediconnect.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared



disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

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

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

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

If you have paid for your covered services **or** If you have paid more than your share for covered services or if you have gotten a bill for the full cost of covered medical services, refer to Chapter 7 Sections A and B to learn what to do.

I1. What to do if services are not covered by our plan

Blue Shield Promise Cal MediConnect Plan covers all services:

- That are determined medically necessary, **and**
- That are listed in the plan's Benefits Chart (refer to Chapter 4 Section D), **and**
- That you get by following plan rules.

If you get services that are not covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will 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 Sections D, E, F, and G explains what to do if you want us to cover a medical item or service. It also tells you how to appeal our coverage decision. You may also call Customer Care to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Customer Care to find out what the limits are and how close you are to reaching them.

J. Coverage of health care services when you are 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. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and find out if you qualify to be in it. You can be in the

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

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

You do need to tell us before you start participating in a clinical research study.

If you plan to be in a clinical research study, you or your care navigator should contact Customer Care to let us know you will be in a clinical trial.

J2. Payment for services when you are in a clinical research study

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

J3. Learning 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 when you get care 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 will cover care in a religious non-medical health care institution.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

K2. Getting 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, the following applies:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
 - You must get approval from us before you are admitted to the facility or your stay will not be covered.

There is no limit on the number of days covered for each hospital stay. To learn more, please refer to the Benefits Chart in Chapter 4, Section D.

L. Durable medical equipment (DME)

L1. DME as a member of our plan

DME means certain items ordered by a provider 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, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Blue Shield Promise Cal MediConnect Plan, you usually will not own DME, no matter how long you rent it.



In certain situations, Blue Shield Promise Cal MediConnect Plan may transfer ownership of the DME item to you depending on if you meet one or all of the following criteria:

- You have a continued medical need for items costing less than \$150 and/or parenteral/infusion pumps
- Physician certification
- If the device or equipment is made to fit you

Call Customer Care to find out about the requirements you must meet and the papers you need to provide.

L2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage 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 Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2022* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) 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.

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 Medicare Advantage 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 a Medicare Advantage plan.

If you made payments for the DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage 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 Medicare Advantage plan to own the DME item.
- There are no exceptions to this case when you return to Original Medicare or a Medicare Advantage plan.

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

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

L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will 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 the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide 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 will rent from a supplier for 36 months.
- your supplier must then provide 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 a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage 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 Blue Shield Promise Cal MediConnect Plan covers and any restrictions or limits on those services and how much you pay for each service. 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 the *Member Handbook*.

Table of Contents

A. Your covered services and your out-of-pocket costs	57
A1. During public health emergencies	57
B. Rules against providers charging you for services	57
C. Our plan's Benefits Chart	57
D. The Benefits Chart	59
E. Benefits covered outside of Blue Shield Promise Cal MediConnect Plan.....	107
E1. California Community Transitions (CCT)	107
E2. Medi-Cal Dental Program.....	107
E3. Hospice care	108
F. Benefits not covered by Blue Shield Promise Cal MediConnect Plan, Medicare, or Medi-Cal.....	109



A. Your covered services and your out-of-pocket costs

This chapter tells you what services Blue Shield Promise Cal MediConnect Plan pays for. It also tells how much you pay for each service. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 Sections B, C, and D. This chapter also explains limits on some services.

For some services, you will be charged an out-of-pocket cost called a copay. This is a fixed amount (for example, \$5) you pay each time you get that service. You pay the copay at the time you get the medical service.

If you need help understanding what services are covered, call your care navigator and/or Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

A1. During public health emergencies

Plans providing required coverage and permissible flexibilities to members subject to a public health emergency declaration (e.g., the COVID-19 pandemic) concisely describe the coverage and flexibilities here or include general information about the coverage and flexibilities along with any cross references, as applicable. Plans include whether such coverage and flexibilities are contingent upon the duration of the public health emergency, which may or may not last for the entire year. Plans also include any specific contact information, as applicable, where members can get more details.

B. Rules against providers charging you for services

We do not allow Blue Shield Promise Cal MediConnect Plan providers to bill you for covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7 Section A or call Customer Care.

C. Our plan's Benefits Chart

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

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

- Your Medicare and Medi-Cal covered services must be provided according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, behavioral health and substance use services, long term services and supports, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.




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. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we will not pay for care you get from an out-of-network provider. Chapter 3 Section D 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 someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3 Section D has more information about getting a referral and explains when you do not need a referral.
- You must get care from providers that are affiliated with your PCP's medical group. Refer to Chapter 3 Sections D for more information.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization first are marked in the Benefits Chart. Refer to Chapter 4 Section D for more information. in italic type.
- All preventive services are free. You will find this apple 🍏 next to preventive services in the Benefits Chart.
- Care Plan Optional (CPO) services may be available under your Individualized Care Plan. These services give you more help at home, like meals, help for you or your caregiver, or shower grab bars and ramps. These services can help you live more independently but do **not** replace long-term services and supports (LTSS) that you are authorized to get under Medi-Cal. Examples of CPO services that Blue Shield Promise Cal MediConnect Plan has offered in the past include: Partners in Care Foundation for case management, assessments and home and community-based services and LifeSpring for home delivered meals. If you need help or would like to find out how CPO services may help you, contact your care navigator.



D. The Benefits Chart

Services that our plan pays for		What you must pay
	<p>Abdominal aortic aneurysm screening</p> <p>We will 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.</p>	\$0

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.




Services that our plan pays for	What you must pay
<p>Acupuncture</p> <p>We will pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.</p> <p>We will also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> • 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. <p>In addition, we will pay for an additional 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.</p> <p>Benefits are provided through a contract with American Specialty Health Plans of California, Inc. (ASH Plans). For more information, or to locate an ASH Plans participating Provider you may call ASH Plans at (800) 678-9133, TTY: (877) 710-2746, Monday through Friday, 5 a.m. to 6 p.m. You can also call Blue Shield Promise Cal MediConnect Customer Care or use Find a Doctor on blueshieldca.com to locate an ASH Plans participating Provider.</p>	<p>\$0</p>





Services that our plan pays for	What you must pay
<p>Additional Telehealth Services</p> <p>Teladoc provides Physician consultations by phone or video 24/7/365. Teladoc Physicians can diagnose and treat basic medical conditions, and can also prescribe certain medication. Teladoc is a supplemental service that is not intended to replace care from your Primary Care Physician. Please log into blueshieldca.com/teladoc or the Blue Shield of California app to request a visit. If you have questions, you may contact Teladoc by phone at 1-800-Teladoc (1-800-835-2363) TTY: 711, 24 hours a day, 7 days a week, 365 days a year.</p>	\$0
<p>Alcohol misuse screening and counseling</p> <p>We will pay for one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p> <p>Brief intervention(s) typically include 1 to 3 sessions, 15 minutes in duration per session, offered in-person, by telephone, or by telehealth modalities.</p>	\$0






Services that our plan pays for	What you must pay
<p>Ambulance services</p> <p>Covered ambulance services include ground, fixed-wing, and rotary-wing ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.</p> <p>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.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	\$0
<p>Annual physical exam</p> <p>You are covered for one routine physical exam every 12 months in addition to your annual wellness visit. This visit includes a comprehensive review of your medical and family history, a detailed head to toe assessment and other services, referrals and recommendations that may be appropriate.</p> <p>Any lab, diagnostic procedures, or other types of services ordered are not covered under this benefit and you pay your plan cost-sharing amount for each of those services separately.</p>	\$0
<p> Annual wellness visit</p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We will pay for this once every 12 months.</p>	\$0




	Services that our plan pays for	What you must pay
	<p>Bone mass measurement</p> <p>We will 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.</p> <p>We will pay for the services once every 24 months, or more often if they are medically necessary. We will also pay for a doctor to look at and comment on the results.</p>	\$0
	<p>Breast cancer screening (mammograms)</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	\$0
	<p>Cardiac (heart) rehabilitation services</p> <p>We will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's <i>referral</i>.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	\$0




	Services that our plan pays for	What you must pay
	<p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the visit <i>or</i> visits, your doctor may:</p> <ul style="list-style-type: none"> • Discuss aspirin use, • Check your blood pressure, and/or • Give you tips to make sure you are eating well. 	\$0
	<p>Cardiovascular (heart) disease testing</p> <p>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.</p>	\$0
	<p>Cervical and vaginal cancer screening</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years 	\$0





Services that our plan pays for		What you must pay
	Chiropractic services We will pay for the following services: <ul style="list-style-type: none"> • Adjustments of the spine to correct alignment 	\$0
	Colorectal cancer screening For people 50 and older, we will pay for the following services: <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years • Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) • Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months. <i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i>	\$0




Services that our plan pays for	What you must pay
<p>Community Based Adult Services (CBAS)</p> <p>CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We will pay for CBAS if you meet the eligibility criteria.</p> <p>Note: If a CBAS facility is not available, we can provide these services separately.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>
<p> Counseling to stop smoking or tobacco use</p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"> We will 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 counseling face-to-face visits. <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> We will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. <p>If you are pregnant, you may get unlimited tobacco cessation counseling with prior authorization.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Dental services</p> <p>Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. Refer to Section F for more information about this benefit.</p> <p>Denti-Cal will cover up to \$1,800 in services every calendar year. Refer to the Denti-Cal website and the California Medi-Cal Dental Services Beneficiary Handbook for more information at www.denti-cal.ca.gov</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>
<p> Depression screening</p> <p>We will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals.</p>	<p>\$0</p>
<p> Diabetes screening</p> <p>We will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<div data-bbox="224 241 267 294"></div> <p>Diabetic self-management training, services, and supplies</p> <p>We will pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> 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 test strips and blood glucose monitors, the preferred manufacturer is Abbott FreeStyle® (made by Abbott) test strips and blood glucose monitors will not require your doctor to get approval in advance (sometimes called “prior authorization”) from the plan. Test strips and blood glucose monitors from all other manufacturers will require your doctor to get approval in advance (sometimes called “prior authorization”) from the plan For people with diabetes who have severe diabetic foot disease, we will pay for the following: <ul style="list-style-type: none"> 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) We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Customer Care. <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “Durable medical equipment (DME),” refer to Chapter 12 of this handbook.)</p> <p>The following items are covered:</p> <ul style="list-style-type: none"> • Wheelchairs • Crutches • Powered mattress systems • Dry pressure pad for mattress • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Enteral pump and supplies • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment <p>Other items may be covered.</p> <p>We will 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.</p> <p>This benefit is continued on the next page</p>	<p>\$0</p>



Services that our plan pays for		What you must pay
	<p>Durable medical equipment (DME) and related supplies (continued)</p> <p><i>Authorization rules may apply. You should talk to your physician and get a referral.</i></p>	\$0





Services that our plan pays for	What you must pay
<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • Given by a provider trained to give emergency services, and • Needed to treat a medical emergency. <p>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:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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. 	<p>\$0</p> <p>You have no combined annual limit for covered emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered <i>OR</i> you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.</p>



Services that our plan pays for	What you must pay
<p>Family planning services</p> <p>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility and related services • Counseling, testing, and treatment for sexually transmitted infections (STIs) • Counseling and testing for HIV and AIDS, and other HIV-related conditions • Permanent Contraception (You must be age 21 or older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • Genetic counseling <p>We will also pay for some other family planning services. However, you must refer to a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> • 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 	<p>\$0 copay for medical and diagnostic services.</p> <p>For prescription items, prescription copays may apply.</p>




Services that our plan pays for	What you must pay
 <p>Health and wellness education programs</p> <p>We offer many programs that focus on certain health conditions. These include:</p> <ul style="list-style-type: none"> • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; and • Nursing Hotline <p>Blue Shield of California Promise Health Plan Nurse Advice Line offers support with registered nurses available to answer questions 24 hours a day, 7 days a week. Call the Nurse Advice Line at (800) 609-4166 (TTY: 711). Nurses are available via phone to respond to general health questions and provide direction to additional resources for more information. With the Nurse Advice Line, members can have a summary of the conversation emailed to them which includes all the information and links for easy reference.</p>	\$0
 <p>Health Club Membership and Fitness Classes</p> <p>SilverSneakers® Fitness</p> <p>Exercise, education, and social activities with access to:</p> <ul style="list-style-type: none"> • Thousands of fitness locations nationwide that you can use anytime. • Exercise equipment and SilverSneakers classes. • Social events and activities. • SilverSneakers FLEX™ classes such as yoga, Latin dance, and tai chi. • Feel like you're at class, without leaving home with SilverSneakers Life 	\$0



Services that our plan pays for	What you must pay
<p>Hearing services</p> <p>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.</p> <p>Blue Shield Promise Cal MediConnect Plan covers up to \$2,000 worth of supplemental hearing aid benefits for both ears combined every benefit year (January 1 – December 31). Hearing aid benefits include:</p> <ul style="list-style-type: none"> • Hearing aids • Molds • Modification supplies • Accessories <p>In addition to the above supplemental benefit, Medi-Cal may cover up to \$1,510 worth of hearing aid benefits every fiscal year (July 1 – June 30).</p> <p>If you are pregnant or reside in a nursing facility, we will also pay for hearing aids, including:</p> <ul style="list-style-type: none"> • Molds, supplies, and inserts • Repairs that cost more than \$25 per repair • 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 <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0 copay</p>



Services that our plan pays for	What you must pay
 <p>HIV screening</p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • Ask for an HIV screening test, or • Are at increased risk for HIV infection. <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p>We will also pay for additional HIV screening(s) when recommended by your provider.</p>	<p>\$0</p>
<p>Home health agency care</p> <p>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.</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Home infusion therapy</p> <p>The plan will pay 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:</p> <ul style="list-style-type: none"> • 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. <p>The plan will cover home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • 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. <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>You pay \$0 for each covered home infusion therapy visit</p>
<p>Home meal delivery</p> <p>Upon discharge from an inpatient hospital or skilled nursing facility (SNF) stay, we cover:</p> <ul style="list-style-type: none"> • 22 meals and 10 snacks per discharge • Meals and snacks will be divided into up to three separate deliveries as needed • Coverage is limited to two discharges per year <p>For more information, you may call Blue Shield Promise Cal MediConnect Plan Customer Care (phone numbers are printed on the back cover of this booklet).</p>	<p>\$0</p>




Services that our plan pays for	What you must pay
<p>Hospice care</p> <p>You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will pay for the following while you are getting hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care <p>This benefit is continued on the next page</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Hospice care (continued)</p> <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare.</p> <ul style="list-style-type: none"> • Refer to Section F of this chapter for more information. • When you are in a hospice program certified by Medicare Part A and B services related to your terminal illness are paid for by Medicare. Blue Shield Promise Cal MediConnect Plan does not pay for these services. <p>For services covered by Blue Shield Promise Cal MediConnect Plan but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • Blue Shield Promise Cal MediConnect Plan will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. <p>For drugs that may be covered by Blue Shield Promise Cal MediConnect Plan's Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 Sections B, C, and D. <p>Note: If you need non-hospice care, you should call your care navigator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. To speak with your care navigator, call Customer Care at the phone number at the bottom of this page and select the care navigator option in the queue.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who has not chosen the hospice benefit.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
 <p>Immunizations</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 Section H to learn more.</p> <p>We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).</p>	<p>\$0</p>
<p>Inpatient hospital care</p> <p>We will pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if it is 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 <p>This benefit is continued on the next page</p>	<p>\$0</p> <p>You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



Services that our plan pays for	What you must pay
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> • 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. <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether 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 Blue Shield Promise Cal MediConnect Plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person.</p> <ul style="list-style-type: none"> • Blood, including storage and administration • Physician services <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p> <p>You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



Services that our plan pays for	What you must pay
<p>Inpatient mental health care</p> <p>We will pay for mental health care services that require a hospital stay.</p> <ul style="list-style-type: none"> • If you need inpatient services in a freestanding psychiatric hospital, we will pay for the first 190 days. After that, the local county mental health agency will pay for inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days will be coordinated with the local county mental health agency. <ul style="list-style-type: none"> ○ 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 will pay for services you got in an Institute for Mental Diseases (IMD). 	<p>\$0</p>





Services that our plan pays for	What you must pay
<p>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</p> <p>If your inpatient stay is not reasonable and medically necessary, we will not pay for it.</p> <p>However, in certain situations where inpatient care is not covered, we may still pay for services you get while you are in a hospital or nursing facility. To find out more, contact Customer Care.</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ Replace all or part of an internal body organ (including contiguous tissue), or ○ Replace all or part of 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 the patient's condition • Physical therapy, speech therapy, and occupational therapy <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>




Services that our plan pays for	What you must pay
<p>Kidney disease services and supplies</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. We will 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 Section D • Inpatient dialysis treatments if you are 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. <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to “Medicare Part B prescription drugs” in this chart.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
 <p>Lung cancer screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • Are aged 50-80, 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. <p>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>
 <p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor.</p> <p>We will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We may approve additional services if medically necessary.</p> <p>We will pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's referral. A doctor must prescribe these services and renew the referral each year if your treatment is needed in the next calendar year. We may approve additional services if medically necessary.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
 <p>Medicare Diabetes Prevention Program (MDPP)</p> <p>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle. <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	\$0
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. Blue Shield Promise Cal MediConnect Plan will pay for the following drugs:</p> <ul style="list-style-type: none"> • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs <p>This benefit is continued on the next page</p>	\$0



Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs (continued)</p> <ul style="list-style-type: none"> Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epoetin Alfa-epbx or Aranesp®) IV immune globulin for the home treatment of primary immune deficiency diseases <p>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.</p> <p>Chapter 5 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.</p>	<p>\$0</p>
<p>Non-emergency medical transportation</p> <p>This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.</p> <p>The forms of transportation are authorized when:</p> <ul style="list-style-type: none"> Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and Transportation is required for the purpose of obtaining needed medical care. <p>Depending on the service, prior authorization may be required.</p> <p>This service is available by calling 1-877-433-2178 (TTY: 711) 24 hours a day, 7 days a week.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>




Services that our plan pays for	What you must pay
<p>Non-medical transportation</p> <p>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.</p> <p>This benefit does not limit your non-emergency medical transportation benefit.</p> <p>We will provide unlimited round-trip transportation to medically necessary covered services, including but not limited to the following:</p> <ul style="list-style-type: none"> • Routine doctor or specialist visits • Pharmacies to pick-up prescriptions that cannot be directly mailed to you • Picking up medical supplies, prosthetics, orthotics and other equipment • Specialty mental health services, substance use disorder services, Denti-Cal services and other services provided by state or county programs. <p>In certain cases, Blue Shield Promise Cal MediConnect Plan will even reimburse a friend or family member for gas each mile they drive you to a covered service or location. Reimbursement will only happen when no other methods of transportation are reasonably available. You cannot drive yourself and if you think a friend or family will have to use their own car to drive you to a covered service or location, please reach out to Blue Shield Promise Cal MediConnect Plan Customer Care before the trip to get approval.</p> <p>This service is available by calling 1-877-433-2178 (TTY 711) 24 hours and 7 days a week.</p> <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Nursing facility care</p> <p>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.</p> <p>Services that we will pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if it is 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 <p>This benefit is continued on the next page</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Nursing facility care (continued)</p> <ul style="list-style-type: none"> • Hearing exams • Chiropractic care • Podiatry services <p>You will 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:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • A nursing facility where your spouse or domestic partner is living at the time you leave the hospital. <p><i>Authorization rules may apply for services. You should talk to your physician and get a referral.</i></p>	\$0
<p> Obesity screening and therapy to keep weight down</p> <p>If you have a body mass index of 30 or more, we will 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.</p>	\$0



Services that our plan pays for	What you must pay
<p>Opioid treatment program (OTP) services</p> <p>The plan will pay for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) 	\$0
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>We will pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0



Services that our plan pays for	What you must pay
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the Provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Outpatient hospital services</p> <p>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:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> ○ Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” ○ Sometimes you can be in the hospital overnight and still be an “outpatient.” ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Outpatient mental health care</p> <p>We will pay for mental health services provided by:</p> <ul style="list-style-type: none"> • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental health care professional as allowed under applicable state laws <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services • Day treatment • Psychosocial rehab services • Partial hospitalization/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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Outpatient rehabilitation services</p> <p>We will pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p> <p>Cardiac (heart) rehabilitation services are for a maximum of 2 one-hour sessions per day up to 36 sessions over 36 weeks.</p> <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0
<p>Outpatient substance abuse services</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0
<p>Outpatient surgery</p> <p>We will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0



Services that our plan pays for	What you must pay
<p>Over-the-counter (OTC) items</p> <p>You are entitled to a quarterly allowance of \$185 for OTC drugs and supplies.</p> <p>Items such as aspirin, vitamins, cold and cough preparations, and bandages are covered under this benefit. Items such as cosmetics and food supplements are not covered under this benefit.</p> <p>The OTC catalog and ordering instructions are available online at www.blueshieldca.com/promise/CMCOTC. You can order items by phone at 1-888-628-2770 (TTY: 711), Monday to Friday between 9:00 a.m. and 5:00 p.m. or online at www.blueshieldca.com/promise/CMCOTC. Orders will be shipped to you at no extra charge. Please allow approximately 14 business days for delivery.</p> <p>This benefit becomes effective the first day of each quarter: January 1, April 1, July 1, and October 1. You can place two orders per quarter and cannot roll over your unused allowance into the next quarter.</p> <p><u>Some limitations may apply. Refer to the OTC Catalog for more information.</u></p>	<p>\$0</p>
<p>Partial hospitalization services</p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.</p> <p>Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.</p> <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Personal Emergency Response System (PERS)</p> <p>PERS is a medical alert monitoring system that provides access to help 24/7, at the push of a button. Your PERS benefits are provided to you by LifeStation®. The benefits you will receive from LifeStation® include:</p> <ul style="list-style-type: none"> • One personal emergency response system • Choice of an in-home system or mobile device with GPS/WiFi • Monthly monitoring • Necessary chargers and cords <p>To obtain the PERS and begin receiving services, call LifeStation's team at 1-855-672-3269, 24 hours a day, seven days a week, or visit www.medicalalertbenefits.com/bscamedicare.</p>	\$0
<p>Physician/provider services, including doctor's office visits</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> ○ 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, if your doctor orders them to find out whether you need treatment <p>This benefit is continued on the next page</p>	\$0




<p>Physician/provider services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> • Certain telehealth services, including those for Physician services to treat non-emergency conditions such as cold and flu symptoms, allergies, bronchitis, respiratory infection, sinus problems, rash, eye infection, migraine and more. <ul style="list-style-type: none"> ○ 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 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 the member's 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 <ul style="list-style-type: none"> ○ 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 <p>This benefit is continued on the next page</p>	<p>\$0</p>
---	------------



Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>
<p>Podiatry services</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>




Services that our plan pays for		What you must pay
	<p>Prostate cancer screening exams</p> <p>For men age 50 and older, we will pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0



Services that our plan pays for	What you must pay
<p>Prosthetic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. We will pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect • Incontinence cream and diapers <p>We will also pay for some supplies related to prosthetic devices. We will also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision Care” later in this section for details.</p> <p>We will not pay for prosthetic dental devices.</p> <p>Prosthetic dental devices may be covered under Denti-Cal. See section F in this chapter or visit www.denti-cal.ca.gov for more information.</p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Pulmonary rehabilitation services</p> <p>We will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have referral for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p>We will pay for respiratory services for ventilator-dependent patients.</p> <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	\$0
<p> Sexually transmitted infections (STIs) screening and counseling</p> <p>We will 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.</p> <p>We will 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 will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p>	\$0



Services that our plan pays for	What you must pay
<p>Skilled nursing facility (SNF) care</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services <p>You will 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:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>




Services that our plan pays for	What you must pay
<p>Supervised exercise therapy (SET)</p> <p>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:</p> <ul style="list-style-type: none"> • 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 <p>The SET program must be:</p> <ul style="list-style-type: none"> • 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 <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p>



Services that our plan pays for	What you must pay
<p>Urgent care</p> <p>Urgent care is care given to treat:</p> <ul style="list-style-type: none"> • A non-emergency that requires immediate medical care, or • A sudden medical illness, or • An injury, or • A condition that needs care right away. <p>If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.</p>	<p>\$0</p> <p>You have no combined annual limit for emergency care or urgently needed services outside the United States and its territories. Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.</p>



Services that our plan pays for	What you must pay
<div data-bbox="224 241 272 294"></div> <p>Vision care</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • One routine eye exam every year; and • Up to \$500 for eyeglasses (frames and lenses) or up to \$500 for contact lenses every two years. <p>We will 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.</p> <p>For people at high risk of glaucoma, we will pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • People with a family history of glaucoma • People with diabetes • African-Americans who are age 50 and older • Hispanic Americans who are 65 or older <p>We will 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).</p> <p><i>Authorization rules may apply to services. You should talk to your physician and get a referral.</i></p>	<p>\$0</p> <p>You are responsible for the cost of materials above the \$500 allowance</p>



Services that our plan pays for	What you must pay
 <p>“Welcome to Medicare” Preventive Visit</p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>	<p>\$0</p>



E. Benefits covered outside of Blue Shield Promise Cal MediConnect Plan

The following services are not covered by Blue Shield Promise Cal MediConnect Plan but are available through Medicare or Medi-Cal.

E1. California Community Transitions (CCT)

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

You can receive 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 will pay for the transition coordination services. You pay nothing for these services.

For services that are not related to your CCT transition:

The provider will bill Blue Shield Promise Cal MediConnect Plan for your services. Blue Shield Promise Cal MediConnect Plan will pay for the services provided after your transition. You pay nothing for these services.

While you are getting CCT transition coordination services, Blue Shield Promise Cal MediConnect Plan will pay for the services that are listed in the Benefits Chart in Section D of this chapter.

No change in Blue Shield Promise Cal MediConnect Plan drug coverage benefit:

Drugs are not covered by the CCT program. You will continue to get your normal drug benefit through Blue Shield Promise Cal MediConnect Plan. For more information, please refer to Chapter 5 Section F.

Note: If you need non-CCT transition care, you should call your care navigator to arrange the services. Non-CCT transition care is care that is not related to your transition from an institution/facility. You can contact your care navigator by calling Blue Shield Promise Cal MediConnect Plan Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week then select the care navigator option when you're in the queue.

E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; for example, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Root canal therapy
- Dentures, adjustments, repairs, and relines

Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, please contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at dental.dhcs.ca.gov/ for more information.

In addition to the fee-for-service Medi-Cal Dental Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Los Angeles County. If you want more information about dental plans, need assistance identifying your dental plan, or want to change dental plans, please 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.

E3. Hospice care

You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Blue Shield Promise Cal MediConnect Plan pays for while you are getting hospice care services.

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

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

For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care):

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

For drugs that may be covered by Blue Shield Promise Cal MediConnect Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5 Section F.

Note: If you need non-hospice care, you should call your care navigator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. You can contact your care



navigator by calling Blue Shield Promise Cal MediConnect Plan Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week then select the care navigator option when you're in the queue.

F. Benefits not covered by Blue Shield Promise Cal MediConnect Plan, Medicare, or Medi-Cal

This section tells you what kinds of benefits are excluded by the plan. Excluded means that we do not pay for these benefits. Medicare and Medi-Cal will not pay for them either.

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

We will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9 Sections D, E, F, and G.

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

- Services considered not “reasonable and medically necessary,” according to the standards of Medicare and Medi-Cal, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. Refer to Chapter 3 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 it is medically necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- 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 will 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 and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



Chapter 5: Getting your outpatient prescription drugs 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 service. They include drugs covered under Medicare Part D and Medi-Cal. Chapter 6 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Blue Shield Promise Cal MediConnect Plan also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some 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 Section D.

Rules for the plan's outpatient drug coverage

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

- You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
- You generally must use a network pharmacy to fill your prescription.
- Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.
 - If it is not on the Drug List, we may be able to cover it by giving you an exception.
 - Refer to Chapter 9 to learn about asking for an exception.
- Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Drugs used to treat conditions not supported by the FDA or reference books are called "off-label" indications. Drugs used for "off-label" indications are not medically accepted indications and thus not a covered benefit unless:
 - This "off-label" use is cited in one of the reference books approved by CMS.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

- Such drugs are cited in two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective (this applies to Medi-Cal requested drugs only).

Table of Contents

A. Getting your prescriptions filled	114
A1. Filling your prescription at a network pharmacy.....	114
A2. Using your Member ID Card when you fill a prescription	114
A3. What to do if you change to a different network pharmacy	114
A4. What to do if your pharmacy leaves the network	114
A5. Using a specialized pharmacy.....	114
A6. Using mail services to get your drugs.....	115
A7. Getting a long-term supply of drugs	117
A8. Using a pharmacy that is not in the plan's network.....	117
A9. Paying you back if you pay for a prescription	117
B. The plan's Drug List	117
B1. Drugs on the Drug List	118
B2. How to find a drug on the Drug List	118
B3. Drugs that are not on the Drug List	118
B4. Drug List cost sharing tiers.....	119
C. Limits on some drugs	119
D. Reasons your drug might not be covered	120
D1. Getting a temporary supply	121
E. Changes in coverage for your drugs.....	122
F. Drug coverage in special cases.....	124



through the plan

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by our plan	124
F2. If you are in a long-term care facility	124
F3. If you are in a Medicare-certified hospice program	125
G. Programs on drug safety and managing drugs	125
G1. Programs to help members use drugs safely	125
G2. Programs to help members manage their drugs	125
G3. Drug management program to help members safely use their opioid medications.....	126



A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we will pay for prescriptions **only** if they are filled at any of our network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care navigator.

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 will bill us for our share of the cost of your covered prescription drug. You may need to pay the pharmacy a copay when you pick up your prescription.

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back for our share. If you cannot pay for the drug, contact Customer Care right away. We will do what we can to help.

- To learn how to ask us to pay you back, refer to Chapter 7 Sections A and B.
- If you need help getting a prescription filled, you can contact Customer Care or your care navigator.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, 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, you can contact Customer Care or your care navigator.

A4. What to do if your pharmacy leaves the network

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

To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care navigator.

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.



through the plan

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.
 - Usually, long-term care facilities have their own pharmacies. If you are a resident of a long-term care facility, we must 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 any difficulty accessing your drug benefits in a long-term care facility, please contact Customer Care.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact Customer Care or your care navigator.

A6. Using mail services to get your drugs

For certain kinds of drugs, you can use the plan's network mail services. Generally, the drugs available through mail service are drugs that you take on a regular basis for a chronic or long-term medical condition. *The drugs that are not available through the plan's mail-order service are marked with [NDS]*

Our plan's mail service allows you to order a 100-day supply for drugs on Tier 1 and 90-days supply for drugs on Tiers 2-3. A 90-day and 100-day supply has the same copay as a one-month supply.

Filling my prescriptions by mail

To get *order forms* and information about filling your prescriptions by mail, please call Blue Shield Promise Cal MediConnect Plan Customer Care using the phone number at the bottom of this page.

Usually, a mail service prescription will get to you within 10 to 14 days. However, sometimes your mail service order may be delayed. If this happens, please call Customer Care for assistance. A representative will assist you in obtaining a sufficient supply of medication from a local retail network pharmacy, so you are not without medication until your mail service medication arrives. This may require contacting your physician to have him/her phone or fax a new prescription to the retail network pharmacy for the necessary quantity of medication needed until you receive your mail service medication.

If the delay is greater than 14 days from the date the prescription was ordered from the mail service pharmacy and the delay is due to a loss of medication in the mail system, Customer Care can coordinate a replacement order with the mail service pharmacy.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Mail service processes

The mail 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 service prescriptions:

1. New prescriptions the pharmacy gets from you

The pharmacy will automatically fill and deliver new prescriptions it gets from you.

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

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

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail service prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program called Automatic Refill program. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail service refills, please contact us by calling CVS Caremark at 1-866-346-7200 (TTY: 711), 24 hours a day, 7 days a week.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Please ensure that your contact information is always up to date with Blue Shield Promise Cal MediConnect Plan. If you need to update your phone number or address, please contact Blue Shield Promise Cal MediConnect Plan Customer Care (phone number located at the bottom of this page).



through the plan

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 100-day supply for drugs on Tier 1 and 90 day supply for drugs on Tier 2-3 has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Customer Care for more information.

For certain kinds of drugs, you can use the plan's network mail services to get a long-term supply of maintenance drugs. Refer to the section above to learn about mail services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

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

- In emergency situations
- When you are out of the service area for up to six (6) months

We recommend that you fill all prescriptions prior to travelling out of area so that you have an adequate supply. If you need assistance with obtaining an adequate supply prior to your departure, please contact Blue Shield Promise Cal MediConnect Customer Care

In these cases, please check first with Customer Care to find out if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

If you must use an out-of-network pharmacy, you will generally have to pay the full cost instead of a copay when you get your prescription. You can ask us to pay you back for our share of the cost.

To learn more about this, refer to Chapter 7 Section A.

B. The plan's Drug List

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

The drugs on the Drug List are selected by us with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under your Medi-Cal benefits.

The Drug List includes both brand name for example Januvia and generic drugs for example Metformin. Generic drugs have the same active ingredients as brand name drugs. Generally, they work just as well as brand name drugs and usually cost less.

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

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.blueshieldca.com/promise/calmediconnect/pharmacy. The Drug List on the website is always the most current one.
- Call Customer Care to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are not on the Drug List

We do not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow us to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Blue Shield Promise Cal MediConnect Plan will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9 Section F.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medi-Cal drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Blue Shield Promise Cal MediConnect Plan for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to



through the plan

treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medi-Cal.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List cost sharing tiers

Every drug on our Drug List is in one of four (4) cost-sharing tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Cost-Sharing Tier 1 (our lowest tier) includes our Preferred Generic Drugs.
- Cost-Sharing Tier 2 includes Generic Drugs.
- Cost-Sharing Tier 3 (our highest tier) includes Brand Drugs
- Cost Sharing Tier 4 includes Non-Medicare drugs and Over-the-counter (OTC) drugs.

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

Chapter 6 Sections C, D, and E tells the amount you pay for drugs in each cost sharing tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, 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 will work 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 will have to 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, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, refer to Chapter 9 Section F2.



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, our network pharmacies will give you the generic version.

- We usually will not pay for the brand name drug when there is a generic version.
- However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug.
- Your copay may be greater for the brand name drug than for the generic drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Blue Shield Promise Cal MediConnect Plan before you fill your prescription. If you don't get approval, Blue Shield Promise Cal MediConnect Plan may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs (that often 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, we will then 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 the Drug List. For the most up-to-date information, call Customer Care or check our website at www.blueshieldca.com/promise/calmediconnect/pharmacy.

D. Reasons your drug might not be covered

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

- The drug you want to take is not covered by our plan. The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

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

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on the Drug List or when it 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 have 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 the plan last year.
 - We will cover a temporary supply of your drug **during the first 90 days of the calendar year.**
 - This temporary supply will be for up to 30 days.
 - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
 - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
 - You are new to our plan.
 - We will cover a temporary supply of your **drug during the first 90 days of your membership in the plan.**
 - This temporary supply will be for up to 30 days.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

- If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
 - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
 - To ask for a temporary supply of a drug, call Customer Care.

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

- You can change to another drug.

There may be a different drug covered by our plan that works for you. You can call Customer Care to ask for a *List of Covered Drugs* that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- You can 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 even though it is not on the Drug List. Or you can 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.

To learn more about asking for an exception, refer to Chapter 9 Section F.

If you need help asking for an exception, you can contact Customer Care or your care navigator.

E. Changes in coverage for your drugs

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

- Decide to require or not require prior approval for a drug. (Prior approval is permission from Blue Shield Promise Cal MediConnect Plan before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally 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 the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

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

- Check our up to date Drug List online at www.blueshieldca.com/promise/calmediconnect/pharmacy **or**
- Call Customer Care to check the current Drug List at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

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

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on 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 or will be lower.

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 Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug’s manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. You should work with your Provider to change to a different drug that will work for your condition and that the plan covers.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
 - Replace a brand name drug currently on the Drug List **or**
 - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 60-day supply of the drug after you ask for a refill.

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

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9 Section F.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will 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 will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by our plan

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

To learn more about drug coverage and what you pay, refer to Chapter 6.

F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living 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, please contact Customer Care.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



F3. If you are in a Medicare-certified hospice program

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

- If you are enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, 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 should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. Refer to the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, refer to Chapter 4 Section D.

G. Programs on drug safety and managing drugs
G1. Programs to help members 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 are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

- 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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact Customer Care or your care navigator.

G3. Drug management program to help members safely use their opioid medications

Blue Shield Promise Cal MediConnect Plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid 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 a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



through the plan

medications after you have a chance to respond, we will 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 file an appeal. If you file 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 will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9.)

The DMP may not apply to you if you:

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



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

Introduction

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

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

Because you are eligible for Medi-Cal, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

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 the *Member Handbook*.

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

- Our *List of Covered Drugs*.
 - We call this the “Drug List.” It tells you:
 - Which drugs we pay for
 - Which of the four (4) cost-sharing tiers each drug is in
 - Whether there are any limits on the drugs
 - If you need a copy of the Drug List, call Customer Care. You can also find the Drug List on our website at www.blueshieldca.com/promise/calmediconnect. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
 - Chapter 5 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 are not covered by our plan.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- *Our Provider and Pharmacy Directory.*
 - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with us.
 - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5 Section A.



Table of Contents

A. The <i>Explanation of Benefits</i> (EOB).....	131
B. How to keep track of your drug costs.....	131
C. Drug Payment Stages for Medicare Part D drugs	132
D. Stage 1: The Initial Coverage Stage	133
D1. Your pharmacy choices.....	133
D2. Getting a long-term supply of a drug	134
D3. What you pay.....	134
D4. End of the Initial Coverage Stage.....	137
E. Stage 2: The Catastrophic Coverage Stage	137
F. Your drug costs if your doctor prescribes less than a full month's supply	137
G. Prescription cost-sharing assistance for persons with HIV/AIDS	138
G1. What the AIDS Drug Assistance Program (ADAP) is	138
G2. What to do if you aren't enrolled in ADAP	138
G3. What to do if you're already enrolled in ADAP	138
H. Vaccinations	138
H1. What you need to know before you get a vaccination	138
H2. What you pay for a Medicare Part D vaccination.....	139



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.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. 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. 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 the total payments made since January 1.
- **Drug price information**. This is the total price of the drug and the percentage change in the drug price since the first fill.
- **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 will not count towards your total out-of-pocket costs.
- We also pay for some over-the-counter drugs. You do not have to pay anything for these drugs.
- To find out which drugs our plan covers, refer to the 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 will help us know what prescriptions you fill and what you pay.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You can ask us to pay you back for our share of the cost of the drug.

Here are some times when you should give us copies of your receipts:

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

To learn how to ask us to pay you back for our share of the cost of the drug, refer to Chapter 7 Sections A and B.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, Blue Shield Promise Cal MediConnect Plan pays all of the costs of your Part D drugs for the rest of the year.

4. Check the EOBs we send you.

When you get an EOB in the mail, please make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, please call Customer Care. Be sure to keep these EOBs. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under Blue Shield Promise Cal MediConnect Plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:



Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
<p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p>	<p>During this stage, we pay all of the costs of your drugs through December 31, 2022.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p>

D. Stage 1: The Initial Coverage Stage

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 what cost-sharing tier the drug is in and where you get it.

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Cost-sharing Tier 1 (our lowest tier) includes Preferred generic drugs. The copay is \$0.
- Cost-sharing Tier 2 includes Generic Drugs. The copay is from \$0 to \$3.95.
- Cost-sharing Tier 3 (our highest tier) includes Brand Drugs. The copay is from \$0 to \$9.85.
- Cost-sharing Tier 4 includes Non-Medicare drugs and over the counter (OTC) drugs. The copay is \$0 .

To find out which cost-sharing tier your drug is in, look for the drug on our Blue Shield Promise Cal MediConnect Plan Formulary (Drug List).

D1. Your pharmacy choices

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

- A network pharmacy, **or**
- An out-of-network pharmacy.

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to Chapter 5 Section A to find out when we will do that.



To learn more about these pharmacy choices, refer to Chapter 5 Section A in this handbook and our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is a 100-day supply for tier 1 and 90-day supply for tiers 2-3. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 Section A or the *Provider and Pharmacy Directory*.

D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you will pay the lower price.

You can contact Customer Care to find out how much your copay is for any covered drug.

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

	A network pharmacy	The plan’s mail service	A network long-term care pharmacy	An out-of-network pharmacy
	A one-month or up to a 30-day supply	A one-month or up to a 30-day supply	Up to a 31-day supply	Up to a 10-day supply. Coverage is limited to certain cases. Refer to Chapter 5 Section A for details.
Cost-sharing				
Tier 1	\$0 copay	Mail service is not available	\$0 copay	\$0 copay
(Preferred Generic Drugs)				



	A network pharmacy	The plan's mail service	A network long-term care pharmacy	An out-of-network pharmacy
	A one-month or up to a 30-day supply	A one-month or up to a 30-day supply	Up to a 31-day supply	Up to a 10-day supply. Coverage is limited to certain cases. Refer to Chapter 5 Section A for details.
Cost-sharing Tier 2 (Generic Drugs)	\$0, \$1.35 or \$3.95 copay Copays vary based on the Extra Help you receive.	Mail service is not available	\$0, \$1.35 or \$3.95 copay Copays vary based on the Extra Help you receive.	\$0, \$1.35 or \$3.95 copay Copays vary based on the Extra Help you receive.
Cost-sharing Tier 3 (Brand Drugs)	\$0, \$4.00 or \$9.85 copay Copays vary based on the Extra Help you receive.	Mail service is not available	\$0, \$4.00 or \$9.85 copay Copays vary based on the Extra Help you receive.	\$0, \$4.00 or \$9.85 copay Copays vary based on the Extra Help you receive.
Cost-sharing Tier 4 (Non-Medicare RX/Over-the-counter (OTC) Drugs)	\$0 copay	Mail service is not available for drugs in tier 4	\$0 copay	\$0 copay

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



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

	A network pharmacy	The plan's mail service
Cost-sharing Tier 1: Preferred Generic Drugs Up to a 100-day supply	\$0 copay	\$0 copay
Cost-sharing Tier 2: Generic Drugs Up to a 90-day supply	\$0, \$1.35 or \$3.95 copay Copays vary based on the Extra Help you receive.	\$0, \$1.35 or \$3.95 copay Copays vary based on the Extra Help you receive.
Cost-sharing Tier 3: Brand Drugs Up to a 90-day supply	\$0, \$4.00 or \$9.85 copay Copays vary based on the Extra Help you receive.	\$0, \$4.00 or \$9.85 copay Copays vary based on the Extra Help you receive.
Cost-sharing Tier 4: Non-Medicare RX/ Over-the-counter (OTC) Drugs Up to a 90-day supply	Long term supply is not available for tier 4	Mail service is not available for drugs in tier 4

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



D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach \$7,050. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOBs will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the \$7,050 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of \$7,050 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

F. Your drug costs if your doctor prescribes less than a full month's supply

Typically, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay will be based on the number of days of the drug that you get. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment will be less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you:
 - better plan when to refill your drugs,
 - coordinate refills with other drugs you take, **and**



- take fewer trips to the pharmacy.

G. Prescription cost-sharing assistance for persons with HIV/AIDS

G1. What the AIDS Drug Assistance Program (ADAP) is

The AIDS Drug Assistance Program (ADAP) helps ensure that eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Office of AIDS for individuals enrolled in ADAP.

G2. What to do if you aren't enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050 or refer to the ADAP website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

G3. What to do if you're already enrolled in ADAP

ADAP can continue to provide ADAP clients with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue getting this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. If you need assistance finding the nearest ADAP enrollment site and/or enrollment worker, please call 1-844-421-7050 or refer to the website listed above.

H. Vaccinations

We cover Medicare Part D 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.

H1. What you need to know before you get a vaccination

We recommend that you call us first at Customer Care whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network



provider should work with Blue Shield Promise Cal MediConnect Plan to ensure that you do not have any upfront costs for a Part D vaccine.

H2. What you pay for a Medicare Part D vaccination

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in Chapter 4 Section D.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
 - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
 - You will pay a copay to the doctor for the vaccine.
 - Our plan will pay for the cost of giving you the shot.
 - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
 - You will pay a copay for the vaccine.
 - Our plan will pay for the cost of giving you the shot.



Chapter 7: Asking us to pay our share of 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 the *Member Handbook*.

Table of Contents

A. Asking us to pay for your services or drugs	141
B. Sending a request for payment.....	143
C. Coverage decisions.....	144
D. Appeals	144



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 you already got. A network provider is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, refer to page 143.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid *more than your share of the cost*, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.
- Contact Customer Care or your care navigator if you have any questions. If you do not know what you should have paid, or if you get a bill and you do not 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

You should ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. 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 do not 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 have already paid more than your share of the cost for the service, we will figure out how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill

Network providers must always bill us. Show your Blue Shield Promise Cal MediConnect Plan Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Customer Care if you get any bills.**

- As a member of Blue Shield Promise Cal MediConnect Plan, you only have to pay the copay when you get services covered by our plan. We do not allow providers to bill

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



you more than this amount. This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and take care of the problem.
- If you have already paid a bill from a network provider, but you feel that you paid too much, send us the bill and proof of any payment you made. We will pay you back for the difference between the amount you paid and the amount you owed under the plan.

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

If you use an out-of-network pharmacy, you will have to 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 for our share of the cost.
- Please refer to Chapter 5 Section A to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call us or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

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

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on our *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
 - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9 Section F).



- If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9 Section F).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

- To learn how to make an appeal, refer to Chapter 9 Section F.

B. Sending a request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can ask your care navigator for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.blueshieldca.com/promise/calmediconnect), or you can call Customer Care and ask for the form.

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

Blue Shield of California Promise Health Plan
Customer Care Department
601 Potrero Grande Drive
Monterey Park, CA 91755

Prescription drug claims:
Blue Shield of California
P.O. Box 52066
Phoenix, AZ 85072-2066

You must submit your claim to us within 365 days of the date you got the service, item, or drug.



C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by our plan. We will also decide the amount of money, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the service or drug, we will mail you a check for what you paid or our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.
- Chapter 3 Section B explains the rules for getting your services covered. Chapter 5 Sections A through F explains the rules for getting your Medicare Part D prescription drugs covered.
- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 Section D.

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 do not agree with the amount we pay.

- The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9 Sections D and E.
- If you want to make an appeal about getting paid back for a health care service, refer to page 174 .
- If you want to make an appeal about getting paid back for a drug, refer to page 190.



Chapter 8: Your rights and responsibilities

Introduction

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

Table of Contents

A. Your right to get information in a way that meets your needs.....	147
B. Our responsibility to ensure that you get timely access to covered services and drugs	154
C. Our responsibility to protect your personal health information (PHI)	155
C1. How we protect your PHI	155
C2. You have a right to look at your medical records.....	155
C3. You have a right to ask us to contact you in a specific way or to send mail to a different address	156
C4. You have the right to ask us to limit what we use and share.....	156
C5. You have a right to choose someone to act for you.....	156
D. Our responsibility to give you information about our plan, our network providers, and your covered services	156
E. Inability of network providers to bill you directly	157
F. Your right to leave our Cal MediConnect Plan	157
G. Your right to make decisions about your health care	158
G1. Your right to know your treatment options and make decisions about your health care	158
G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself	158
G3. What to do if your instructions are not followed.....	159
H. Your right to make complaints and to ask us to reconsider decisions we have made	159
H1. What to do if you believe you are being treated unfairly or you would like more information about your rights.....	160

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



I. Your responsibilities as a member of the plan	161
--	-----



If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.

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

We must tell you about the 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 Customer Care. Our plan has people who can answer questions in different languages.
- Our plan can also give you materials in formats such as large print, braille, or audio. Materials are available in Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukranian, Vietnamese:
 - You can make a standing request to get this document in a language other than English or in an alternate format now and in the future. To make a request, please contact Blue Shield Promise Cal MediConnect Plan Customer Care.
 - Blue Shield Promise Cal MediConnect Plan Customer Care will keep your preferred language and format on file for future communications. To make any updates on your preference, please contact Blue Shield Promise Cal MediConnect Plan.

If you are having 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. For Medi-Cal benefits, you can also ask for a State Hearing if the health plan denies, reduces, or ends services you think you should get. To ask for a Medi-Cal State Hearing and file a complaint, call 1-800-952-5253. TTY users should call 1-800-952-8349

- Estamos obligados a darle información sobre los beneficios del plan y sus derechos de una manera que usted pueda comprender. Estamos obligados a darle información sobre sus derechos todos los años en que usted sea miembro de nuestro plan.
- Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios para los Miembros. Nuestro plan cuenta con personas que pueden responder preguntas en diferentes idiomas.
 - Nuestro plan también puede brindarle materiales en otros idiomas además del español y en formatos como letra grande, braille o audio. Para el condado de Los Angeles, los materiales están disponibles en inglés, vietnamita, chino, armenio, ruso, tagalo, coreano, farsi, árabe y camboyano. Para el condado de San Diego, los materiales están disponibles en inglés, vietnamita, tagalo y árabe. Puede realizar una solicitud permanente para recibir los materiales en un idioma que no sea inglés o en un formato alternativo ahora y en el futuro. Para realizar una solicitud, póngase en contacto con el

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Departamento de Servicios para los miembros de Blue Shield Promise Cal MediConnect Plan.

- Si está teniendo inconvenientes para recibir información de nuestro plan por problemas relacionados con el idioma o con 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 siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. Para los beneficios de Medi-Cal, también puede pedir una Audiencia estatal imparcial si el plan de salud deniega, reduce o cancela servicios que usted cree que debería recibir. Para pedir una Audiencia estatal imparcial de Medi-Cal y presentar una queja, llame al 1-800-952-5253. Los usuarios de TTY deben llamar al 1-800-952-8349.

我們必須用您能了解的方式，告訴您計劃的福利和您的權利。您加入本計劃期間，我們每年都必須把您的權利告訴您。

要以您能了解的方式取得資訊，請致電會員服務部。本計劃有專人能用各種語言回答您的疑問。

- 本計劃也能向您提供英語以外其他語言的資料，並以大字體、盲人點字或語音等格式提供資料。在Los Angeles縣，可提供的資料語言有西班牙文、越南文、中文、亞美尼亞文、俄羅斯文、塔加洛文、韓文、法爾西文、阿拉伯文和柬埔寨文。在San Diego縣，可提供的資料語言有西班牙文、越南文、塔加洛文和阿拉伯文。您可來電Blue Shield Promise Cal MediConnect Plan會員服務部，要求收到英語以外其他語言和／或其他格式的資料。您可以立即或在日後申請獲得英語以外的其他語言版本或備選格式的材料。如需申請，請聯絡第一健保(Blue Shield Promise Cal MediConnect Plan)會員服務部。
- 如果您因為語言方面的問題或因為殘疾而無法自本計劃取得資訊，而您希望提出投訴，請致電聯邦醫療保健計劃(Medicare)，電話1-800-MEDICARE (1-800-633-4227)。每週七天辦公，每天24小時。聽障和語障人士可致電1-877-486-2048。關於Medi-Cal福利，如果健保計劃拒絕、縮減或終止您認為您應該可取得的服務時，您也可要求舉行州公平聽證會。如欲要求舉行Medi-Cal州公平聽證會和提出投訴，請致電1-800-952-5253。聽障和語障人士可致電1-800-952-8349。
- Chúng tôi phải cho quý vị biết về các quyền lợi của chương trình và các quyền của quý vị theo cách thức quý vị có thể hiểu được. Chúng tôi phải cho quý vị biết về các quyền của quý vị vào mỗi năm quý vị tham gia chương trình của chúng tôi.
- Để nhận được thông tin theo cách thức quý vị có thể hiểu được, vui lòng gọi ban Dịch vụ hội viên. Chương trình của chúng tôi có các nhân viên có thể trả lời các câu hỏi bằng các ngôn ngữ khác nhau.
 - Chương trình của chúng tôi cũng có thể cung cấp cho quý vị các tài liệu bằng các ngôn ngữ ngoài tiếng Anh và dưới các dạng như bản in cỡ lớn,

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



chữ nổi braille hoặc âm thanh. Đối với Quận Los Angeles, có sẵn các tài liệu bằng tiếng Tây Ban Nha, tiếng Việt, tiếng Hoa, tiếng Armenia, tiếng Nga, tiếng Tagalog, tiếng Hàn, tiếng Farsi, tiếng Ả-rập và tiếng Cam-pu-chia. Đối với Quận San Diego, có sẵn các tài liệu bằng tiếng Tây Ban Nha, tiếng Việt, tiếng Tagalog và tiếng Ả-rập. Quý vị cũng có thể yêu cầu nhận các tài liệu bằng các ngôn ngữ ngoài tiếng Anh và/hoặc dưới dạng khác bằng cách gọi cho ban Phục vụ hội viên của Blue Shield Promise Cal MediConnect Plan

- Nếu quý vị đang gặp khó khăn khi nhận thông tin từ chương trình của chúng tôi vì các vấn đề ngôn ngữ hoặc tình trạng khuyết tật và quý vị muốn nộp đơn khiếu nại, vui lòng gọi Medicare theo số 1-800-MEDICARE (1-800-633-4227). Quý vị có thể gọi 24 giờ một ngày, bảy ngày trong tuần. Người dùng TTY cần gọi số 1-877-486-2048. Đối với các quyền lợi Medi-Cal, quý vị cũng có thể yêu cầu Phiên điều trần công bằng cấp tiểu bang nếu các chương trình bảo hiểm y tế từ chối, giảm trừ hoặc chấm dứt các dịch vụ quý vị nghĩ rằng quý vị sẽ nhận được. Để yêu cầu Phiên điều trần công bằng cấp tiểu bang Medi-Cal và nộp đơn khiếu nại, vui lòng gọi số 1-800-952-5253. Người dùng TTY cần gọi số 1-800-952-8349.
- Մենք ծրագրի նպաստների և Ձեր իրավունքների մասին Ձեզ պետք է տեղեկացնենք Ձեզ հասկանալի եղանակով: Մենք Ձեր իրավունքների մասին Ձեզ պետք է տեղեկացնենք ամեն տարի, որ գտնվում եք մեր ծրագրում:
- Ձեզ հասկանալի եղանակով տեղեկություն ստանալու համար զանգահարեք մեր Անդամների սպասարկում: Մեր ծրագրում կան անձեր, ովքեր հարցերին կարող են պատասխանել տարբեր լեզուներով:
 - Մեր ծրագիրը կարող է նյութերը Ձեզ տալ նաև անգլերենից տարբեր լեզուներով և ձևաչափերով, ինչպես՝ խոշոր տպատառերով, Բրայլյան այբուբենով կամ ձայնագրված: Լուս Անջելես վարչաշրջանի համար նյութերը տրամադրելի են իսպաներենով, վիետնամերենով, չինարենով, հայերենով, ռուսերենով, տազալերենով, կորեերենով, պարսկերենով, արաբերենով և կամբոջերենով: Սան Դիեգո վարչաշրջանի համար նյութերը տրամադրելի են իսպաներենով, վիետնամերենով, տազալերենով և արաբերենով: Կարող եք նյութերը անգլերենից տարբեր լեզուներով և/կամ այլընտրական ձևաչափով ստանալու խնդրանք ներկայացնել զանգահարելով Blue Shield Promise Cal MediConnect ծրագրի Անդամների սպասարկում:
 - Եթե դժվարանում եք մեր ծրագրից տեղեկություն ստանալ լեզվական խնդիրների կամ հաշմանդամության պատճառով և ուզում եք զանգատ ներկայացնել, զանգահարեք Medicare՝ 1-800-MEDICARE (1-800-633-4227) համարով: Կարող եք զանգահարել օրը 24 ժամ,

շաբաթը յոթ օր: TTY-ից օգտվողները պետք է զանգահարեն 1-877-486-2048 համարով: Medi-Cal-ի նպաստների համար, կարող եք նաև Նահանգային արդար լուսմ ինսդրել, եթե առողջապահական ծրագիրը մերժի, նվազեցնի կամ դադարեցնի ծառայություններ, որոնք կարծում եք, որ պետք է ստանաք: Medi-Cal-ի Նահանգային արդար լուսմ ինսդրելու և զանգատ ներկայացնելու համար, զանգահարեք 1-800-952-5253 համարով: TTY-ից օգտվողները պետք է զանգահարեն 1-800-952-8349 համարով:

- Мы обязаны рассказать вам в понятной для вас форме о преимуществах плана и ваших правах. Мы обязаны рассказывать вам о ваших правах ежегодно на протяжении вашего участия в нашем плане.
- Позвоните в Отдел обслуживания участников (Customer Care) для получения информации в понятной для вас форме. Сотрудники нашего плана могут ответить на ваши вопросы на разных языках.
 - Наш план может также предоставить вам материалы на других языках, помимо английского, напечатанные крупным шрифтом, шрифтом Брайля или в аудио формате. Для округа Лос-Анджелес материалы доступны на испанском, вьетнамском, китайском, армянском, русском, тагальском, корейском, языке фарси, арабском и камбоджийском языках. Для округа Сан-Диего материалы доступны на испанском, вьетнамском, тагальском и арабском языках. Вы можете подать запрос на получение материалов на других языках, помимо английского, и/или в альтернативном формате, позвонив в Отдел обслуживания участников плана Blue Shield Promise Cal MediConnect.
 - Если у вас возникают проблемы с получением информации от нашего плана из-за языковых проблем или в связи с ограниченными возможностями, и Вы хотите подать жалобу, позвоните в программу Medicare по номеру 1-800-MEDICARE (1-800-633-4227). Вы можете звонить по этому номеру 24 часа в сутки, без выходных. Пользователям линии TTY следует обращаться по номеру 1-877-486-2048. Одним из преимуществ программы Medi-Cal является то, что вы всегда можете подать запрос о проведении Объективного слушания дела на уровне штата (State Hearing), если план медицинского страхования отказывается от предоставления услуг, сокращает или прекращает предоставление услуг, которые, на ваш взгляд, должны быть вам предоставлены. Для подачи запроса о проведении Объективного слушания дела на уровне штата и обращения с жалобой звоните по номеру 1-800-952-5253.



Пользователям линии TTY следует обращаться по номеру
1-800-952-8349.

- Dapat naming sabihin sa iyo ang tungkol sa mga benepisyo ng plano at ang iyong mga karapatan sa paraang mauunawaan mo. Dapat naming sabihin sa iyo ang tungkol sa iyong mga karapatan sa bawat taon na ikaw ay nasa aming plano.
- Upang makatanggap ng impormasyon sa paraang mauunawaan mo, tawagan ang Mga Serbisyo sa Miyembro. Ang aming plano ay may mga tauhan na makakasagot ng iyong mga tanong sa iba't ibang wika.
 - Maaari ka ring bigyan ng aming plano ng mga materyal na nasa iba't ibang wika maliban sa Ingles at sa mga format na tulad ng malaking print, braille o audio. Para sa Los Angeles County, mayroong mga materyal sa Spanish, Vietnamese, Chinese, Armenian, Russian, Tagalog, Korean, Farsi, Arabic at Cambodian. Para sa San Diego County, mayroong mga materyal sa Spanish, Vietnamese, Tagalog, Hmong at Arabic. Maaari kang maghain ng kahilingan para makatanggap ng mga materyal sa iba't ibang wika maliban sa Ingles at/o sa alternatibong format sa pamamagitan ng pagtawag sa Mga Serbisyo sa Miyembro ng Blue Shield Promise Cal MediConnect.
 - Kung nagkakaroon ka ng problema sa pagtanggap ng impormasyon mula sa aming plano dahil sa mga problema sa wika o sa isang kapansanan at gusto mong maghain ng reklamo, tawagan ang Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kang tumawag 24 na oras sa isang araw, pitong araw sa isang linggo. Dapat tumawag ang mga gumagamit ng TTY sa 1-877-486-2048. Para sa mga benepisyo ng Medi-Cal, maaari ka ring humiling para sa isang Patas na Pagdinig ng Estado kung tinanggihan, binawasan o tinapos ng planong pangkalusugan ang mga serbisyo na sa palagay mo ay dapat mong matanggap. Upang humiling sa Medi-Cal ng Patas na Pagdinig ng Estado at maghain ng reklamo, tumawag sa 1-800-952-5253. Dapat tumawag ang mga gumagamit ng TTY sa 1-800-952-8349.
- 저희는 귀하가 이해할 수 있는 방식으로 플랜의 혜택 및 귀하의 권리에 관해 귀하에게 설명해야 합니다. 저희는 귀하가 저희 플랜에 가입되어 있는 동안 매년 귀하의 권리에 관해 귀하에게 설명해야 합니다.
- 귀하가 이해할 수 있는 방식으로 정보를 받으시려면 가입자 서비스에 전화하십시오. 저희 플랜에는 여러 가지 언어로 질문에 답변할 수 있는 직원들이 있습니다.
 - 저희 플랜은 또한 영어 이외의 언어로 된 자료 및 대형 활자 인쇄본, 점자 또는 오디오와 같은 형식으로 된 자료를 귀하에게 제공할 수 있습니다. 로스앤젤레스 카운티의 경우 자료들은 스페인어, 베트남어, 중국어,

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



아르메니아어, 러시아어, 타갈로그어, 한국어, 페르시아어, 아랍어 및 캄보디아어로 이용할 수 있습니다. 샌디에고 카운티의 경우 자료들은 스페인어, 베트남어, 타갈로그어 및 아랍어로 이용할 수 있습니다. **Blue Shield Promise Cal MediConnect Plan** 가입자 서비스에 전화하시면 영어 이외의 언어로 된 자료 및/또는 다른 형식으로 된 자료를 요청하실 수 있습니다.

- 언어 문제 또는 장애로 인해 저희 플랜에서 정보를 받는데 문제가 있고 이에 대한 불만을 접수하시려면 **1-800-MEDICARE (1-800-633-4227)**번으로 **Medicare**에 전화하십시오. 주 7일, 24시간 동안 언제든지 전화하실 수 있습니다. **TTY** 이용자는 **1-877-486-2048**번으로 전화하십시오. **Medi-Cal** 혜택의 경우 귀하가 받아야 한다고 생각하는 서비스를 건강보험에서 거부, 축소 또는 종료한 경우 귀하는 주정부 공정심의회를 요청하실 수 있습니다. 주정부 공정심의회 요청 및 불만 접수를 하시려면 **1-800-952-5253**번으로 전화하십시오. **TTY** 이용자는 **1-800-952-8349** 번으로 전화하십시오.

ما باید موضوعات مربوط به مزایای برنامه درمانی و حقوق شما را به صورتی بیان کنیم که برایتان قابل فهمیدن باشد. ما باید حقوق شما را در هر سالی که در برنامه درمانی عضویت دارید برایتان توضیح دهیم.

- برای دریافت اطلاعات به صورتیکه برایتان قابل فهمیدن باشد، با خدمات اعضا تماس بگیرید. برنامه درمانی ما اشخاصی را در استخدام دارد که می توانند به سؤالات به زبان های گوناگون پاسخ دهند.

- برنامه درمانی ما می تواند اطلاعات را به زبان هایی به غیر از انگلیسی و به فرمت هایی از قبیل چاپ درشت، بریل یا صوتی نیز به شما ارائه کند. برای کانتی لس آنجلس، اطلاعات به زبان های اسپانیایی، ویتنامی، چینی، ارمنی، روسی، تاگالوگ، کره ای، فارسی، عربی و کامبوجی موجود هستند. برای کانتی سن دیگو، اطلاعات به زبان های اسپانیایی، ویتنامی، تاگالوگ و عربی موجود می باشند. توسط تماس با خدمات اعضای **Blue Shield Promise Cal MediConnect Plan** می توانید درخواست کنید که نشریات را به زبان های دیگری به غیر از انگلیسی و/یا فرمت متفاوتی دریافت کنید.

- اگر به خاطر مشکلات زبانی یا معلولیت در دریافت اطلاعات از برنامه درمانی ما با مشکلی مواجه هستید و می خواهید شکایتی را تسلیم کنید، با **Medicare** به شماره **1-800-MEDICARE (1-800-633-4227)** تماس بگیرید. می توانید در **24** ساعت شبانهروز و **هفت** روز هفته تماس بگیرید. کاربران **TTY** باید با شماره **1-877-486-2048** تماس بگیرند. برای مزایای **Medi-Cal**، اگر برنامه درمانی از ارائه خدماتی که فکر می کنید باید دریافت کنید امتناع کرد، آنها را کاهش یا خاتمه داد، می توانید برای دادرسی عادلانه ایالتی نیز درخواست کنید. برای درخواست دادرسی عادلانه ایالتی **Medi-Cal** و تسلیم شکایت، با شماره **1-800-952-5253** تماس بگیرید. کاربران **TTY** باید با شماره **1-800-952-8349** تماس بگیرند.

យើងត្រូវតែប្រាប់អ្នក អំពីអត្ថប្រយោជន៍របស់កំរោង និងសិទ្ធិរបស់អ្នក ក្នុងរបៀបដែលអ្នកអាចយល់បាន។ យើងត្រូវតែប្រាប់អ្នក អំពីសិទ្ធិរបស់អ្នក ជារៀងរាល់ឆ្នាំ ថាអ្នកនៅក្នុងកំរោងរបស់យើង។

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825

TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. For more information, visit www.blueshieldca.com/promise/calmediconnect.



- ដើម្បីទទួលបានព័ត៌មាន ក្នុងរបៀបដែលអ្នកអាចយល់បាន សូមទូរស័ព្ទទៅផ្នែកសេវាសមាជិក។ គំរោងរបស់យើងមានមនុស្សដែលអាច ឆ្លើយសំណួរជាភាសាផ្សេងៗ។
- គំរោងរបស់យើង ក៏អាចឱ្យសំភារៈទៅអ្នក ជាភាសាផ្សេងទៀតក្រៅពីអង់គ្លេស និងជាទំរង់ដូចជាអក្សរពុម្ពធំៗ អក្សរច្រាល ឬថាសសំឡេងផងដែរ។ សំរាប់ខោនធី Los Angeles សំភារៈគឺមានជា ភាសាអេស៉្បាញ៉ូល, វៀតណាម, ចិន, អាមេរិក, រូស្ស៊ី, តាហ្គាឡុក, គូរេ, ហ្វីលីពីន, អារ៉ាប់, និង ខ្មែរ។ សំរាប់ខោនធី San Diego សំភារៈគឺមានជាភាសាអេស៉្បាញ៉ូល, វៀតណាម, តាហ្គាឡុក, និង អារ៉ាប់។ អ្នកអាចស្នើសុំទទួលសំភារៈជាភាសាផ្សេងទៀតក្រៅពីអង់គ្លេស និង/ឬ ជាទំរង់ផ្សេងទៀត ដោយទូរស័ព្ទទៅផ្នែកសេវាសមាជិក Blue Shield Promise Cal MediConnect Plan។
- បើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគំរោងរបស់យើង ពីព្រោះបញ្ហាខាងភាសា ឬភាពពិការ ហើយអ្នក ចង់ប្តឹងបណ្តឹង សូមទូរស័ព្ទទៅ Medicare តាមលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចទូរស័ព្ទទៅ 24 ម៉ោងមួយថ្ងៃ ប្រាំពីរថ្ងៃមួយអាទិត្យ។ អ្នកប្រើ TTY គួរតែហៅលេខ 1-877-486-2048។ សំរាប់ អត្ថប្រយោជន៍ Medi-Cal អ្នកក៏អាចស្នើសុំសេវាអ្នកជួយផងដែរ បើគំរោងសុខភាព បដិសេធ កាត់បន្ថយ ឬបញ្ចប់សេវា ដែលអ្នកគិតថាអ្នកគួរតែទទួល។ ដើម្បីស្នើសុំសេវាអ្នកជួយផងដែរ Medi-Cal និងប្តឹងបណ្តឹង សូមទូរស័ព្ទទៅលេខ 1-800-952-5253។ អ្នកប្រើ TTY គួរតែហៅលេខ 1-800-952-8349។

يجب علينا إخبارك بمزايا الخطة وبحقوقك بطريقة يمكنك فهمها. ويجب علينا إخبارك بحقوقك في كل سنة تشترك فيها في خطتنا.

- للحصول على المعلومات بطريقة يمكنك فهمها، يُرجى الاتصال بقسم خدمات الأعضاء. تتضمن الخطة أشخاصًا يمكنهم الإجابة على الاستفسارات بمختلف اللغات.
- يمكن أن توفر الخطة أيضًا موادًا بلغات مختلفة خلاف اللغة الإنجليزية وبتنسيقات مختلفة مثل، الطباعة بأحرف كبيرة أو بطريقة برايل أو كمواد سمعية. وبالنسبة لمقاطعة لوس أنجلوس، تتوفر المواد باللغات الإسبانية والفيتنامية والصينية والألمانية والروسية والتاجالوجية والكورية والفارسية والعربية والكمبودية. وبالنسبة لمقاطعة سان دييغو، تتوفر المواد باللغات الإسبانية والفيتنامية والتاجالوجية والعربية. ويمكنك تقديم طلب للحصول على المواد بلغات أخرى خلاف اللغة الإنجليزية و/أو بالتنسيقات البديلة عن طريق الاتصال بقسم خدمات الأعضاء التابع لخطة Blue Shield Promise Cal MediConnect Plan.

- الاتصال إذا كنت تواجه مشكلة في الحصول على المعلومات من الخطة بسبب مشاكل اللغة أو الإعاقة وترغب في تقديم شكوى، يُرجى ببرنامج Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. ويرجى العلم بأن إمكانية الاتصال متاحة على مدار 24 ساعة ولمدة 7 أيام في الأسبوع. (TTY) وعلى مستخدمي الهاتف النصي الاتصال على الرقم 1-877-486-2048. وبالنسبة للمشاكل المتعلقة بمزايا برنامج Medi-Cal، يمكنك أيضًا طلب عقد جلسة استماع عادلة بالولاية إذا قامت الخطة برفض أو تخفيض أو إيقاف توفير خدمات تعتقد بأنه يحق لك الحصول عليها. ولطلب

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825

TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. For more information, visit www.blueshieldca.com/promise/calmediconnect.



عقد جلسة استماع عادلة بالولاية خاصة ببرنامج Medi-Cal وتقديم شكوى، يمكنك الاتصال على الرقم 1-800-952-5253. وعلى مستخدمي الهاتف النصي (TTY) الاتصال على الرقم 1-800-952-8349.

B. Our responsibility to ensure that you get timely access to covered services and drugs

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 Section D.
 - Call Customer Care or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use someone 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 cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3 Section D.
- 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 Section F.
- You have the right to self-direct care with help from your care team and care navigator.

Chapter 9 Sections A and B tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 Sections E through J also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



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

We protect your personal health information (PHI) as required by federal and state laws.

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

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

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

In most situations, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release PHI to government agencies that are checking on our quality of care.
- We are required to release PHI by court order.
- We are required to give Medicare your PHI. If Medicare releases your PHI for research or other uses, it will be done according to federal laws.

C2. You have a right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your PHI has been shared with others by asking for a list or accounting of the times we have shared your health information for six years prior to the date you ask who we shared it with, and why. We will include all the disclosures except for those about treatment, payment and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



C3. You have a right to ask us to contact you in a specific way or to send mail to a different address

- You have the right to ask for Confidential Communication.
- We may say “no” to your request, but we will tell you why in writing within 60 days.

C4. You have the right to ask us to limit what we use and share

- You have the right to ask us not to use or share certain health information for treatment, payment or our operations.
- We are not required to agree with your request, and we may say “no” if it would affect your care.

C5. You have a right to choose someone to act for you

- If you have given someone Power of Attorney for Health Care or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

If you have questions or concerns about the privacy of your PHI, call the Blue Shield of California Privacy Office at 1-888-266-8080.

D. Our responsibility to give you information about our plan, our network providers, and your covered services

As a member of Blue Shield Promise Cal MediConnect Plan, you have the right to get information from us. If you do not speak English, we have interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. This is a free service to you. The *Member Handbook* and other important materials are available in languages other than English. Materials can also be made available in Armenian, Cambodian, Chinese, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Mien, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, Vietnamese. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
 - Financial information

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- How we have been rated by plan members
- The number of appeals made by members
- How to leave our plan
- Our network providers and our network pharmacies, including:
 - How to choose or change primary care providers
 - Qualifications of our network providers and pharmacies
 - How we pay providers in our network
- Covered services and drugs and about rules you must follow, including:
 - Services and drugs 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, 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 charge you if we pay less than the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to Chapter 7.

F. Your right to leave our Cal MediConnect 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 a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Refer to Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- Your Medi-Cal benefits will continue to be offered through Blue Shield Promise Cal MediConnect Plan unless you choose a different plan available in this county.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. 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 the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told 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 go to 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 also have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, you will not be dropped 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 has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 Sections D, E, and F tells how to ask the plan 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

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

- Fill out a written form to **give someone the right to make health care decisions for you.**

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

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

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medi-Cal such as the Health Insurance Counseling and Advocacy Program (HICAP) may also have advance directive forms. You can also contact Customer Care to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**
 - The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
 - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

G3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with Livanta BFCC-QIO Program, the Quality Improvement Organization (QIO), for the state of California, at 1-877-588-1123 (TTY: 711 or 1-855-887-6668).

H. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 Sections D through F tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Customer Care.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 – or you would like more information about your rights, you can get help by calling:

- Customer Care.
- Health Insurance Counseling and Advocacy Program (HICAP) program. For details about this organization and how to contact it, refer to Chapter 2 Section E.
- The Cal MediConnect Ombuds Program. For details about this organization and how to contact it, refer to Chapter 2 Section I.
- 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 member of the plan

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

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
 - Covered services, refer to Chapters 3 and 4. 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.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Customer Care if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
 - Give them the 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 are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' 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 Blue Shield Promise Cal MediConnect Plan members, Medi-Cal pays for your Part A premium and your Part B premium.
 - For some of your long-term services and supports or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



a copay (a fixed amount) **or** coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your long-term services and supports. Chapter 6 Section D tells what you must pay for your drugs.

- **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to Chapter 9 Sections D through J to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Customer Care.
 - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Blue Shield Promise Cal MediConnect Plan. Chapter 1 Section D tells about our service area.
 - We can help you figure out whether you are 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 let you know if we have a plan in your new area.
 - Also, be sure to let Medicare and Medi-Cal know your new address when you move. Refer to Chapter 2 Sections G and H for phone numbers for Medicare and Medi-Cal.
 - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- Call Customer Care 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 has said it will not pay for.
- You disagree with a decision your plan has 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.

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

If you are facing a problem with your health or long-term services and supports

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 are having a problem with your care, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call the Cal MediConnect 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 for more information on ombudsman programs.

Table of Contents

A. What to do if you have a problem	166
A1. About the legal terms	166
B. Where to call for help.....	166
B1. Where to get more information and help	166
C. Problems with your benefits.....	167
C1. Using the process for coverage decisions and appeals or for making a complaint	167

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m, seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



D. Coverage decisions and appeals.....	168
D1. Overview of coverage decisions and appeals	168
D2. Getting help with coverage decisions and appeals.....	168
D3. Using the section of this chapter that will help you	169
E. Problems about services, items, and drugs (not Part D drugs)	171
E1. When to use this section	171
E2. Asking for a coverage decision.....	172
E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)	174
E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)	177
E5. Payment problems	182
F. Part D drugs	184
F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug	184
F2. What an exception is	185
F3. Important things to know about asking for exceptions	186
F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception	187
F5. Level 1 Appeal for Part D drugs.....	190
F6. Level 2 Appeal for Part D drugs.....	192
G. Asking us to cover a longer hospital stay	193
G1. Learning about your Medicare rights.....	193
G2. Level 1 Appeal to change your hospital discharge date	194
G3. Level 2 Appeal to change your hospital discharge date	197
G4. What happens if you miss an appeal deadline	197
H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon	199



H1. We will tell you in advance when your coverage will be ending	200
H2. Level 1 Appeal to continue your care	200
H3. Level 2 Appeal to continue your care	202
H4. What happens if you miss the deadline for making your Level 1 Appeal	203
I. Taking your appeal beyond Level 2	205
I1. Next steps for Medicare services and items.....	205
I2. Next steps for Medi-Cal services and items	206
J. How to make a complaint	206
J1. What kinds of problems should be complaints	206
J2. Internal complaints.....	208
J3. External complaints	209



A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medi-Cal approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

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

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

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

B. Where to call for help

B1. Where to get more information and help

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

You can get help from the Cal MediConnect Ombuds Program

If you need help, you can always call the Cal MediConnect Ombuds Program. The Cal MediConnect Ombuds Program is an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free. Refer to Chapter 2 for more information on ombudsman programs.

You can get help from the Health Insurance Counseling and Advocacy Program

You can also call 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 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.

Getting help from Medicare

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



You can call Medicare directly for help with problems. 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: 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

You can get help from the California Department of Managed Health Care

In this paragraph, the term “grievance” means an appeal or complaint about Medi-Cal services, your health plan, or one of your providers.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-855-905-3825 (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.dmhca.gov has complaint forms, IMR application forms and instructions online.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help 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, long-term services and supports, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes.

My problem is about
benefits or coverage.

Refer to **Section D: “Coverage decisions and appeals”** on page 168.

No.

My problem is not about
benefits or coverage.

Skip ahead to **Section J: “How to make a complaint”** on page 206.

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment. You are not responsible for Medicare costs except Part D copays.

What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor are not sure if a service, item, or drug is covered by Medicare or Medi-Cal, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medi-Cal. If you or your doctor disagree with our decision, you can appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Customer Care** at 1-855-905-3825 (TTY: 711).

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. The phone number is 1-855-501-3077.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Call the **Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people enrolled in Cal MediConnect 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.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Customer Care 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. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may 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. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. You can ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.
 - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E on page 171** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- You are not getting medical care you want, and you believe our plan covers this care.
- We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
 - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List with a “NPD” are not covered by Part D. Refer to Section F on page 184 for Part D drug appeals.
- You got medical care or services you think should be covered, but we are not paying for this care.
- You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
 - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 193 and 199.
- **Section F on page 184** gives you information about Part D drugs. For example, use this section if:
 - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
 - You want to ask us to waive limits on the amount of the drug you can get.
 - You want to ask us to cover a drug that requires prior approval.
 - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
 - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 193** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:



- You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section H on page 199** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Customer Care at 1-855-905-3825 (TTY: 711).

If you need other help or information, please call the Cal MediConnect Ombuds Program at 1-855-501-3077.

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term services and supports (LTSS). You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with a "NPD" are **not** covered by Part D. Use Section F for Part D drug Appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover medical, behavioral health, or long-term services and supports (LTSS) you need but are not getting.

What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 172 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 174 for information on making an appeal.

3. You got services or items 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 E3 on page 174 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

What you can do: You can ask us to pay you back. Refer to Section E5 on page 182 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 174 for information on making an appeal.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections G or H on pages 193 and 199 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get medical, behavioral health, or certain long-term services and supports (CBAS or NF services)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-855-905-3825 TTY: 711.
- You can fax us at: 1-323-889-6577
- You can write to us at: Blue Shield of California Promise Health Plan
Customer Care Department
601 Potrero Grande Drive
Monterey Park, CA 91755

How long does it take to get a coverage decision?

After you ask and we get all of the information we need, it usually takes 5 business days for us to make a decision unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we do not give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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



Asking for a fast coverage decision:

- Start by calling or faxing to ask us to cover the care you want.
- Call us at 1-855-905-3825 (TTY: 711) or fax us at 1-323-889-5049.
- Find other details on how to contact us in Chapter 2.

You can also ask your provider or your representative to request a fast coverage decision for you.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for care or an item you have not yet received.** (You cannot ask for a fast coverage decision if your request is about payment for care or an item you already got.)
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.**
 - If your doctor says that you need a fast coverage decision, we will automatically give you one.
 - If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
 - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell 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 the process for making complaints, including fast complaints, refer to Section J on page 206.

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).



E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can appeal.

In most cases, you must start your appeal at Level 1. If you do not want to first appeal to the plan for a Medi-Cal service, if your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an Independent Medical Review from the Department of Managed Health Care at www.dmhca.ca.gov. Refer to page 177 for more information. If you need help during the appeals process, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plans.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to check if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-855-905-3825 (TTY: 711). For additional details on how to reach us for appeals, refer to Chapter 2.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
- You can submit a written request to the following address:

Blue Shield of California Promise Health Plan
Member Appeals and Grievances

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal (refer to page 174).
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is in process (refer to page 177).
- Keep reading this section to learn about what deadline applies to your appeal.

601 Potrero Grande Drive
Monterey Park, CA 91755

- You can submit your request online at:
www.blueshieldca.com/promise/calmediconnect
- You may also ask for an appeal by calling us at 1-855-905-3825 (TTY: 711).
- We will send you a letter within 5 calendar days of receiving your appeal letting you know that we received it.

The legal term for “fast appeal” is “expedited reconsideration.”

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Customer Care and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

If the appeal comes from someone besides you or your doctor or other provider, we must get the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an appeal?

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 appeals” on page 177 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Customer Care at 1-855-905-3825 (TTY: 711).

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



We take a careful look at all of the information about your request for coverage of medical care. Then, we check if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a “standard” appeal decision?

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
- If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 177.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is 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 service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 177.

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- If we do not give you an answer to your appeal within 72 hours, we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
- If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 177.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.



If our answer is 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 service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, refer to Section E4 on page 177.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service or item that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service or item. You must **make the request on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item while your appeal is processing.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare or Medi-Cal.

- If your problem is about a **Medicare** service or item, we will 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 **Medi-Cal** service or item, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to our plan.

My problem is about a Medi-Cal service or item. How can I make a Level 2 Appeal?

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

(1) Independent Medical Review

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



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

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

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

You are entitled to both an IMR and a State Hearing, but not if you have already had a State Hearing on the same issue.

In most cases, you must file an appeal with us before requesting an IMR. Refer to page 174 for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

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

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

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

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx or call the DMHC Help Center at 1-888-466-2219. TDD 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.dmhca.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx
or call the Department's Help Center at 1-888-466-2219. TDD users should call 1-877-688-9891.

- Mail or fax your forms and any attachments to:

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

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

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

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

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

(2) State Hearing

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

In most cases **you have 120 days to ask for a State Hearing** after the "Your Hearing Rights" notice is mailed to you.

NOTE: If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page 181 for more information.

There are two ways to ask for a State Hearing:



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

State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, California 94244-2430
 - To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.
2. You can call the California Department of Social Services at 1-800-952-5253. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.



- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription.

Will my benefits continue during Level 2 appeals?

If your problem is about a service or item covered by Medicare, your benefits for that service or item will not continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medi-Cal and you ask for a State Hearing, your Medi-Cal benefits for that service or item can continue until a hearing decision is made. You must ask for a hearing **on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item until the hearing decision is made.

How will I find out about the decision?

If your Level 2 Appeal was an Independent Medical Review, the Department of Managed Health Care will send you a letter explaining the decision made by the doctors who reviewed your case.

- If the Independent Medical Review decision is **Yes** to part or all of what you asked for, we must provide the service or treatment.
- If the Independent Medical Review decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. You can still get a State Hearing. Refer to page 179 for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, the California Department of Social Services will send you a letter explaining its decision.

- If the State Hearing decision is **Yes** to part or all of what you asked for, we must comply with the decision. We must complete the described action(s) within 30 calendar days of the date we received a copy of the decision.
- If the State Hearing decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. We may stop any aid paid pending you are receiving.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or



item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was an Independent Medical Review, you can request a State Hearing. Refer to page 179 for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, you may ask for a rehearing within 30 days after you receive the decision. You may also ask for judicial review of a State Hearing denial by filing a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after you receive the decision. You cannot ask for an IMR if you already had a State Hearing on the same issue.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

Refer to Section I on page 205 for more information on additional levels of appeal.

E5. 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. The only amount you should be asked to pay is the copay for brand and generic prescription drugs.

If you get a bill that is more than your copay 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.

For more information, start by reading Chapter 7: "Asking us to pay our share of a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for your share of a service or item I paid for?



Remember, if you get a bill that is more than your copay for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is a covered service or item, and we will check 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 your provider our share of the cost for the service or item within 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 174. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 30 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE 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 you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 205 for more information on additional levels of appeal.



If we answer **No** to your appeal and the service or item is usually covered by Medi-Cal, you can file a Level 2 Appeal yourself (refer to Section E4 on page 177).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medi-Cal may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with a “NPD”. These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with “NPD” symbol follow the process in Section E on page 171.

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

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

- You ask us to make an exception such as:
 - Asking us to cover a Part D drug that is not on the plan’s Drug List
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan’s Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

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

The legal term for a coverage decision about your Part D drugs is “**coverage determination.**”

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.

Use the chart below to help you decide which section has information for your situation:



Which of these situations are you in?

<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section F2 on page 185. Also refer to Sections F3 and F4 on pages 186 and 187.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section F4 on page 187.</p>	<p>Do you want to ask us to pay you back for a drug you already got and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section F4 on page 187.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section F5 on page 190.</p>
---	---	--	---

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an “exception.”

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

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

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

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3 for brand name drugs or Tier 2 for generic drugs.



- You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer to Chapter 5 Section C).
- The extra rules and restrictions on coverage for certain drugs include:
 - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - Quantity limits. For some drugs, we limit the amount of the drug you can have.
 - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception**.”

F3. Important things to know about asking for exceptions

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 requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, 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 request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 190 tells how to make an appeal if we say **No**.

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



F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-855-905-3825 (TTY: 711).
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D on page 168 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

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



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

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

You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
 - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
 - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 206.

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, this means within 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.



- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, this means within 72 hours after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor’s or prescriber’s supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.



F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-855-905-3825 (TTY: 711).
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.
- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Customer Care at 1-855-905-3825 (TTY: 711).

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan “redetermination.”

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section F4 on page 187.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



The legal term for “fast appeal” is “**expedited redetermination.**”

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check that we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
 - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.



- If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Customer Care at 1-855-905-3825 (TTY: 711).
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is “**reconsideration.**”

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”
- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are 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.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any 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 are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. 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.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Read this notice carefully and ask questions if you don't understand. The "Important Message" 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 are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Customer Care at 1-855-905-3825 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. 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. The call is free.
- You can also refer to the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNH/HospitalDischargeAppealNotices.
- If you need help, please call Customer Care or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to find out if your planned discharge date is medically appropriate for you. In California, the Quality Improvement Organization is called Livanta BFCC-QIO.

To make an appeal to change your discharge date call Livanta BFCC-QIO at: 1-877-588-1123 (TTY: 1-855-887-6668).

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. "An Important Message from Medicare about Your Rights" contains information on how to reach the Quality Improvement Organization.



- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, refer to Section G4 on page 197.
- 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 E4 on page 177 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for a “fast review”.

Call before you leave the hospital and before your planned discharge date.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care at 1-855-905-3825 (TTY: 711). You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Or you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a “fast review”

You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review” is **“immediate review.”**

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample by calling Customer Care at 1-855-905-3825 (TTY: 711). 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. Or you can refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal as described in the next section.



G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: **1-877-588-1123 (TTY: 1-855-887-6668)**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page 177 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check that the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes to your fast review**, it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.
- It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
 - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the Independent Review Entity. When we do this, it means that your case is automatically going to Level 2 of the appeals process.

At a glance: How to make a Level 1 Alternate Appeal

Call our Customer Care number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 206 tells how to make a complaint.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

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 E4 on page 177 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.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



are getting treatment for an illness or accident, or you are recovering from a major operation.

- With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
- When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.” The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying our share of the cost for your care.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 206 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Care at 1-855-905-3825 (TTY: 711). Or call your State Health Insurance Assistance Program at 1-877-839-2675.



During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: 1-877-588-1123 (TTY: 1-855-887-6668). Information about appealing to the Quality Improvement Organization is also in the “Notice of Medicare Non-Coverage”. This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, refer to Section H4 on page 203.
- 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 E4 on page 177 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is “**Notice of Medicare Non-Coverage.**” To get a sample copy, call Customer Care at 1-855-905-3825 (TTY: 711) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or refer to a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

What happens during the Quality Improvement Organization’s review?

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is “**Detailed Explanation of Non-Coverage.**”

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: 1-877-588-1123 (TTY: 1-855-887-6668). Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-877-588-1123 (TTY: 1-855-887-6668) and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.
- 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 E4 on page 177 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.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check that the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.
- It also means that we agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- **If we say No** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

At a glance: How to make a Level 1 Alternate Appeal

Call our Customer Care number and ask for a “fast review.”

We will give you our decision within 72 hours.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “**expedited appeal.**”

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 206 tells how to make a complaint.



During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section E4 on page 177 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

I. Taking your appeal beyond Level 2

I1. 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 your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.



If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Cal MediConnect Ombuds Program at 1-855-501-3077.

I2. Next steps for Medi-Cal services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medi-Cal. If you do not agree with the State Hearing decision and you want another judge to review it, you may ask for a rehearing and/or seek judicial review.

To ask for a rehearing, mail a written request (a letter) to:

The Rehearing Unit
744 P Street, MS 19-37
Sacramento, CA 95814

This letter must be sent within 30 days after you get your decision. This deadline can be extended up to 180 days if you have a good reason for being late.

In your rehearing request, state the date you got your decision and why a rehearing should be granted. If you want to present additional evidence, describe the additional evidence and explain why it was not introduced before and how it would change the decision. You may contact legal services for assistance.

To ask for judicial review, you must file a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after receiving your decision. File your petition in the Superior Court for the county named in your decision. You may file this petition without asking for a rehearing. No filing fees are required. You may be entitled to reasonable attorney's fees and costs if the Court issues a final decision in your favor.

If a rehearing was heard and you do not agree with the decision from the rehearing, you may seek judicial review but you cannot request another rehearing.

J. How to make a complaint

J1. 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, and customer service. Here are examples of the kinds of problems handled by the complaint process.



Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Blue Shield Promise Cal MediConnect Plan staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Customer Care or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Customer Care or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 209.



Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a “complaint” is a **“grievance.”**

The legal term for “making a complaint” is **“filing a grievance.”**

Are there different types of complaints?

Yes. 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 that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

J2. Internal complaints

To make an internal complaint, call Customer Care at 1-855-905-3825 (TTY: 711). You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must file it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Customer Care 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.
- We will acknowledge receipt of your written grievance within five (5) days of receiving it. We will conduct a review of your issues. We may request your medical records as part of our review. We will mail you a response to your complaint within thirty (30) days of receiving your complaint. We must address your grievance as quickly as your case requires based on your health status, but no later than thirty (30) days after receiving your complaint.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.” If you have a “fast complaint,” it means we will give you an answer within 24 hours.



- Complaints related to Medicare Part D must be made within 60 calendar days after you had the problem you want to complain about. All other types of complaints must be filed with us or the Provider within 60 calendar days from the day the incident or action occurred that caused you to be dissatisfied.
- We will attempt to resolve your telephone complaint as quickly as possible. If we cannot resolve your complaint by the next business day, we will send you an acknowledgment letter within 5 calendar days of receiving your complaint letting you know that we received it.
- If you have an urgent problem (not related to a denial) that involves an immediate and serious risk to your health, you can request a “fast complaint” and we will respond within 72 hours.

The legal term for “fast complaint” is “expedited grievance.”

If possible, we will 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 do not make a decision within 30 calendar days because we need more information, we will notify you in writing. We will also provide a status update and estimated time for you to get the answer.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- **If we do not agree** with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

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



If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell Medi-Cal about your complaint

The Cal MediConnect Ombuds Program also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we must provide. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan.

The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free.

You can tell the California Department of Managed Health Care about your complaint

The California Department of Managed Health Care (DMHC) is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan's decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website (www.dmhc.ca.gov).

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights office at:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TTY: (800) 537-7697
Email: ocrmail@hhs.gov.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



You may also have rights under the Americans with Disability Act and under ADA Amendments Act of 2008 (P.L. 110-325). You can contact the Cal MediConnect Ombuds Program for assistance. The phone number is 1-855-501-3077.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to Chapter 2.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. The phone number for Livanta BFCC-QIO is 1-877-588-1123 (TTY: 1-855-887-6668).



Chapter 10: Ending your membership in our Cal MediConnect plan

Introduction

This chapter tells about ways you can end your membership in our Cal MediConnect plan and your health coverage options after you leave the 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 the *Member Handbook*.

Table of Contents

A. When you can end your membership in our Cal MediConnect plan.....	213
B. How to end your membership in our Cal MediConnect plan	213
C. How to join a different Cal MediConnect plan	215
D. How to get Medicare and Medi-Cal services separately	215
D1. Ways to get your Medicare services.....	215
D2. How to get your Medi-Cal services.....	217
E. Keep getting your medical services and drugs through our plan until your membership ends	217
F. Other situations when your membership in our Cal MediConnect plan ends	218
G. Rules against asking you to leave our Cal MediConnect plan for any health-related reason	219
H. Your right to make a complaint if we end your membership in our plan	219
I. How to get more information about ending your plan membership	220



A. When you can end your membership in our Cal MediConnect plan

You can end your membership in Blue Shield Promise Cal MediConnect Plan Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Cal MediConnect plan, or moving to Original Medicare.

Your membership will end 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 will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example).

When you end your membership in our plan, you will be enrolled in a Medi-Cal managed care plan of your choice for your Medi-Cal services, unless you choose a different Cal MediConnect plan. You can also choose your Medicare enrollment options when you end your membership in our plan. If you leave our plan, you can get information about your:

- Medicare options in the table on page 215.
- Medi-Cal services on page 217.

You can get more information about how you can end your membership by calling:

- Customer Care at 1-855-905-3825 (TTY: 711) 8:00 a.m. to 8:00 p.m., seven days a week.
- 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.
- State Health Insurance Assistance Program (SHIP), 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/.
- Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- 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.

NOTE: If you're in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

B. How to end your membership in our Cal MediConnect plan

If you decide to end your membership, tell Medi-Cal or Medicare that you want to leave Blue Shield Promise Cal MediConnect Plan:

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- 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; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 216.



C. How to join a different Cal MediConnect plan

If you want to keep getting your Medicare and Medi-Cal benefits together from a single plan, you can join a different Cal MediConnect plan.

To enroll in a different Cal MediConnect plan:

- 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. Tell them you want to leave Blue Shield Promise Cal MediConnect Plan and join a different Cal MediConnect plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with Blue Shield Promise Cal MediConnect Plan will end on the last day of the month that we get your request.

D. How to get Medicare and Medi-Cal services separately

If you do not want to enroll in a different Cal MediConnect plan after you leave Blue Shield Promise Cal MediConnect, you will go back to getting your Medicare and Medi-Cal services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our Cal MediConnect plan.



<p>1. You can change to:</p> <p>A Medicare health plan, such as a Medicare Advantage Plan or, if you meet eligibility requirements and live within the service area, a Program of All-inclusive Care for the Elderly (PACE)</p>	<p>Here is what to do:</p> <p>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.</p> <p>For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • 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/. <p>You will automatically be disenrolled from Blue Shield Promise Cal MediConnect Plan when your new plan's coverage begins.</p>
<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</p> <p>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.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • 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/. <p>You will automatically be disenrolled from Blue Shield Promise Cal MediConnect Plan when your Original Medicare coverage begins.</p>



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 don't 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 will automatically be disenrolled from Blue Shield Promise Cal MediConnect Plan when your Original Medicare coverage begins.

D2. How to get your Medi-Cal services

If you leave our Cal MediConnect plan, you will be enrolled in a Medi-Cal managed care plan of your choice.

Your Medi-Cal services include most long-term services and supports and behavioral health care.

When you ask to end your membership in our Cal MediConnect plan, you will need to let Health Care Options know which Medi-Cal managed care plan you want to join.

- 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. Tell them you want to leave Blue Shield Promise Cal MediConnect Plan and join a Medi-Cal managed care plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

When you end your membership with our Cal MediConnect plan, you will get a new Member ID Card, a new *Member Handbook*, and a new *Provider and Pharmacy Directory* for your Medi-Cal coverage.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



If you leave Blue Shield Promise Cal MediConnect Plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. Refer to page 213 for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail service pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Cal MediConnect plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership in our Cal MediConnect plan ends

These are the cases when Blue Shield Promise Cal MediConnect Plan must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal. The Department of HealthCare Services (DHCS) or the Centers for Medicare and Medicaid Services (CMS) may disenroll you if it is determined that you are not eligible for the program.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Customer Care to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for 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 will notify us if you are not eligible to remain a member on this basis.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



- We must disenroll you if you do not meet this requirement.

If you no longer qualify for Medi-Cal or your circumstances have changed that make you no longer eligible for Cal MediConnect, you may continue to get your benefits from Blue Shield Promise Cal MediConnect Plan for an additional two-month period. This additional time will allow you to correct your eligibility information if you believe that you are still eligible. You will get a letter from us about the change in your eligibility with instructions to correct your eligibility information.

- To stay a member of Blue Shield Promise Cal MediConnect Plan, you must qualify again by the last day of the two-month period.
- If you do not qualify by the end of the two-month period, you'll be disenrolled from Blue Shield Promise Cal MediConnect Plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you 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.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our Cal MediConnect plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should **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.

You should also **call the Cal MediConnect Ombuds Program** at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our Cal MediConnect 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 Section J for information about how to make a complaint.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can:

- Call Customer Care at 1-855-905-3825 (TTY:711), 8:00 a.m. to 8:00 p.m., seven days a week.
- 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.
- 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/.
- Call the Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- 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.



Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in Blue Shield Promise Cal MediConnect Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Notice about laws	222
B. Notice about nondiscrimination.....	222
C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort	222
D. Notice about third party liability	222
E. Nondiscrimination notice	222



A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Medi-Cal must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, or sex. *In addition, we don't discriminate or treat you differently because of your ancestry, marital status, or sexual orientation.*

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 your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Customer Response Center: (800) 368-1019
Fax: (202) 619-3818
TTY: (800) 537-7697
Email: ocrmail@hhs.gov

If you have a disability and need help accessing health care services or a provider, call Customer Care. If you have a complaint, such as a problem with wheelchair access, Customer Care can help.

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



The Cal MediConnect program complies with State and Federal laws and regulations relating to the legal liability of third parties for health care services to members. We will take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

D. Notice about third party liability

If you suffer an injury or illness for which a third party is liable due to a negligent or intentional act or omission causing such illness or injury, we will send you a statement of the reasonable charges for services provided in connection with the injury or illness. Charges shall be calculated as shown below. However, you will not be required to make any payment to us until financial responsibility has been established through settlement of the matter, court judgment or otherwise.

Should you recover any sums from the responsible third party, you must promptly notify us of the same. We shall be reimbursed out of such recovery from a third party for the charges set forth in the statement we sent you, subject to the limits set forth in the following paragraphs.

a) The amount of our lien shall be calculated as follows:

- i. For health care services not provided on a capitated basis, the amount actually paid by the Plan, Medical Group or Independent Practice Association to the treating medical provider; or
- ii. If the services were provided on a capitated basis, eighty percent (80%) of the usual and customary charge for the same services provided on a non-capitated basis in the same geographic area where the services were provided.
- iii. If both non-capitated and capitated services were provided to you, and our contracting provider of the capitated services pays for the non-capitated services you received, then any such lien may not exceed the sum of:
 - (i) the reasonable costs actually paid to perfect the lien, and
 - (ii) the amounts determined pursuant to “a” and “b” above.

b) Our maximum lien recovery is subject to the following limitations:

- i. If you engaged an attorney, then the lien may not exceed the lesser of the following amounts:
 - (i) The maximum amount determined under #1 above; or
 - (ii) One-third (1/3) of the monies that you are entitled to receive under any final judgment, compromise or settlement agreement.
- ii. If you did not engage an attorney, then the lien may not exceed the lesser of the following amounts:
 - (i) The maximum amount determined under #1 above; or
 - (ii) One-half (1/2) of the monies that you are entitled to receive under any final judgment, compromise or settlement agreement.

c) Our lien recoveries are subject to these further reductions:



- i. If a judge, jury or arbitrator makes a special finding that you were partially at fault, our lien recovery shall be reduced by the same comparative fault percentage that your recovery was reduced.
- ii. A pro rata reduction for your reasonable attorney's fees (if any) and costs.

The above limits on lien recoveries do not apply to Workers' Compensation liens.

Subject to the limitations stated above, you grant to Blue Shield of California Promise Health Plan an assignment of, and a claim and a lien against, any amounts so recovered through settlement, judgment or verdict. You may be required by us to execute documents and to provide information necessary to establish the assignment, claim, or lien to ascertain the right to recovery.

Also, we have, by contract, delegated to its providers the right to assert third-party lien rights against our members for health care services the provider rendered to, or arranged for them.

Contracting Medical Groups, Physicians and Independent Practice Associations asserting lien rights against members must do so in accordance with the procedures set forth above.

E. Nondiscrimination notice

Discrimination is Against the Law

Blue Shield of California Promise Health Plan complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people or treat them differently, on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability or physical disability.

Blue Shield of California Promise Health Plan provides:

- Aids and services at no cost to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Language services at no cost to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the Blue Shield of California Promise Health Plan Civil Rights Coordinator.

If you believe that Blue Shield of California Promise Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability or physical disability, you can file a grievance with:

Blue Shield of California Promise Health Plan
Civil Rights Coordinator
601 Potrero Grande Dr.
Monterey Park, CA 91755

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Phone: (844) 883-2233 (TTY: 711)
Fax: (323) 889-2228
Email: BSCPHPCivilRights@blueshieldca.com

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

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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Care.



If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.

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.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (Refer to Chapter 9 Section E for more information). This continued coverage is called “aid paid pending.”

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 Section E explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Cal MediConnect: A program that provides both your Medicare and Medi-Cal benefits together in one health plan. You have one Member ID Card for all your benefits.

Care navigator: 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.”

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the \$7,050 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 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 Enrollees who meet applicable eligibility criteria.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



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.

Copay: A fixed amount you pay as your share of the cost each time you get certain prescription drugs. For example, you might pay \$2 or \$5 for a prescription drug.

Cost sharing: Amounts you have to pay when you get certain prescription drugs. Cost sharing includes copays.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of four (4) cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 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 covered by our plan.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Customer Care: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 Section A for information about how to contact Customer Care.



Daily cost sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment will be less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.

Department of Health Care Services (DHCS): The State department in California that administers the Medicaid Program (referred to as Medi-Cal in California), generally referred to as "the State" in this handbook.

Department of Managed Health Care (DMHC): The State department in California that is responsible for regulating health plans. The DMHC helps people in Cal MediConnect with appeals and complaints about Medi-Cal services. The DMHC also conducts Independent Medical Reviews (IMR).

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of four (4) tiers.

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 is 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 function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are 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 that is not normally covered or to use the drug without certain rules and limitations.

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



Generic drug: A prescription drug that is 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 is 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 Section E 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 navigators to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not 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 do not have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

An enrollee who has a terminal prognosis has the right to elect hospice.

A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.

Blue Shield Promise Cal MediConnect Plan must 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 the plan's cost sharing amount for services. Show your Blue Shield Promise Cal MediConnect Plan Member ID Card when you get any services or prescriptions. Call Customer Care if you get any bills you do not understand.

As a member of Blue Shield Promise Cal MediConnect Plan, you only have to pay the plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to bill you more than this amount.



Independent Medical Review (IMR): If we deny your request for medical services or treatment, you can file an appeal with us. 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 is decided in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Part D drug expenses reach \$7,050. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

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 instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs covered by the plan. The plan chooses 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 are services that help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing home or hospital. LTSS include Community Based Adult Services (CBAS) and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to “Extra Help.”

Medi-Cal: This is the name of California’s Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government.

It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

It covers extra services and some drugs not covered by Medicare.

Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825 TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit www.blueshieldca.com/promise/calmediconnect.



Refer to Chapter 2 Section H for information about how to contact Medi-Cal.

Medi-Cal Plans: Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. The Medi-Cal definition of medical necessity limits health care services to those necessary to protect life, to prevent significant illness, or significant disability, or to alleviate severe pain.

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 Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medi-Cal enrollee (Dual Eligible): A person who qualifies for Medicare and Medi-Cal coverage. A Medicare-Medi-Cal enrollee is also called a “dually eligible individual.”

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like 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 that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program “Part D” for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medi-Cal. Blue Shield Promise Cal MediConnect Plan includes Medicare Part D.



Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medi-Cal may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are 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 the health plan and accept our payment and not charge our members an extra amount.

While you are a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

Nursing home or facility: A place that provides care for people who cannot get their care at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information about the Cal MediConnect Ombuds Program in Chapters 2 and 9 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 Sections D, E, and F explains how to ask us for a coverage decision.



Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).

Original Medicare is available everywhere in the United States.

If you do not 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. Most drugs you get from out-of-network pharmacies are not covered by our plan 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 Section D explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine 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 Blue Shield Promise Cal MediConnect Plan’s Notice of Privacy Practices for more information about how Blue Shield Promise Cal MediConnect Plan protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.



Primary care provider (PCP): Your primary care provider is 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 for information about getting care from primary care providers.

Prior authorization: An approval from Blue Shield Promise Cal MediConnect Plan you must get before you can get a specific service or drug or use an out-of-network provider. Blue Shield Promise Cal MediConnect Plan may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

Covered services that need our plan's prior authorization are marked in the Benefits Chart in Chapter 4.

Some drugs are covered only if you get prior authorization from us.

Covered drugs that need our plan's prior authorization are marked in the *List of Covered Drugs*.

Program for All-Inclusive Care for the Elderly (PACE) Plans: A program that covers Medicare and Medi-Cal benefits together for people age 55 and older who need a higher level of care to live at home.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items 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. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.



Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, Blue Shield Promise Cal MediConnect Plan 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 Chapter 3 and about services that require referrals in Chapter 4.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 to learn more about rehabilitation services.

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 is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get Blue Shield Promise Cal MediConnect Plan.

Share of cost: The portion of your health care costs that you may have to pay each month before Cal MediConnect benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we will not approve, or we will not 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 first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgent care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



Blue Shield Promise Cal MediConnect Plan Customer Care

CALL	<p>1-855-905-3825</p> <p>Calls to this number are free. Seven days a week. 8:00 a.m. to 8:00 p.m.</p> <p>Customer Care also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Seven days a week. 8:00 a.m. to 8:00 p.m.</p>
WRITE	<p>Blue Shield of California Promise Health Plan Customer Care Department 601 Potrero Grande Drive Monterey Park, CA 91755</p>
WEBSITE	<p>www.blueshieldca.com/promise/calmediconnect</p>

If you have questions, please call Blue Shield Promise Cal MediConnect Plan at 1-855-905-3825
TTY: 711, 8:00 a.m. to 8:00 p.m., seven days a week. The call is free. **For more information**, visit
www.blueshieldca.com/promise/calmediconnect.

