# Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Blue Shield TotalDual Plan (HMO D-SNP)

Los Angeles and San Diego Counties

January 1, 2023 - December 31, 2023


MA005-EOC-TD LASD-1022

blue california

# Blue Shield TotalDual Plan (HMO D-SNP) *Member Handbook*

***H5982_22_378A_C SNR 09192022***

**January 1, 2023 – December 31, 2023**

# Your Health and Drug Coverage under Blue Shield TotalDual Plan

## *Member Handbook* Introduction

This *Member Handbook, otherwise known as the Evidence of Coverage,* tells you about your coverage under our plan through December 31, 2023. 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 your *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Blue Shield TotalDual Plan.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame (800) 452-4413 (TTY: 711) de 8:00 a.m. a 8:00 p.m., los 7 días de la semana.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 (800) 452-4413 (TTY: 711) 每週七天辦公，早上8:00 點至 晚上8:00 點或。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 452-4413 (TTY: 711) 8 giờ sáng–8 giờ tối, 7 ngày trong tuần. HOẶC Ban.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 452-4413 (TTY: 711)

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 452-4413 (TTY: 711)번으로 전화해 주십시오,오후 8시, 7 일 주일 오전 8시

Հայերեն (Armenian): ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 452-4413 (TTY (հեռատիպ)՝ 711)

فارسی (Persian/Farsi): توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) تماس بگیرید (800) 452-4413.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 452-4413 (телетайп: 711).

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。 (800) 452-4413 (TTY:711) まで、お電話にてご連絡ください。

العربية (Arabic): ملحوظة :إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (711: رقم هاتف الصم والبكم) (800) 452-4413 (711: رقم هاتف الصم والبكم)

ਪੰਜਾਬੀ (Punjabi): ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 452-4413 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Cambodian/Khmer): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (800) 452-4413 (TTY:711)។

Hmoob (Hmong): LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 452-4413 (TTY:711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (800) 452-4413 (TTY:711) पर कॉल करें।

ภาษาไทย (Thai): เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 452-4413 (TTY:711).

اُردُو (Urdu) : خبردار :اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں (800) 452-4413 (TTY:711).

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-800-452-4413 (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 TotalDual Plan Customer Care. They will keep your preferred language and format on file for future communications. To make any updates on your preference, please contact Blue Shield TotalDual Plan.

## Disclaimers

- Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2024.

- The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

- It is our plan's responsibility to coordinate your Medi-Cal (Medicaid) benefits for you.

- Blue Shield of California is an HMO and an HMO D-SNP plan with a Medicare contract and a contract with the California State Medi-Cal (Medicaid) Program. Enrollment in Blue Shield of California depends on contract renewal

- Coverage under Blue Shield TotalDual 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 TotalDual Plan, a health plan that covers all of your Medicare services and coordinates all of your and Medi-Cal services. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

## Table of Contents

## A. Welcome to our plan

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

## 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 Medi-Cal (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 to pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of California approved our plan. You can get Medicare and Medi-Cal services through our plan as long as:

- We choose to offer the plan, **and**
- Medicare and the State of California allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Medi-Cal services is not affected.

## C. Advantages of our plan

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

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

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care coordinator.
- Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

**New members to** Blue Shield TotalDual Plan: In most instances you will be enrolled in Blue Shield TotalDual Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in Blue Shield TotalDual Plan. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Blue Shield Promise Health Plan. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week if you have any questions.

## D. Our plan's service area

Our service area includes these counties in California: Los Angeles and San Diego Counties.

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

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

## E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

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

Call Customer Care for more information.

Please note: if you lose your eligibility but can reasonably be expected to regain eligibility within 6 month(s), then you are still eligible for membership in our plan (Chapter 4, Section A tells you about coverage and cost sharing during this period, which is called deemed continued eligibility).

## F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your effective enrollment date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA include questions to identify your medical, LTSS, and behavioral health and functional needs.

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

We'll send you more information about this HRA.

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

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
    - We determine an existing relationship by reviewing your available health information available or information you give us.
    - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days.
    - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

**Note:** You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services not included in our plan. You **cannot** make this request for providers of DME, transportation or other ancillary providers.

After the continuity of care period ends, you will need to use doctors and other providers in the Blue Shield TotalDual 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** of your *Member Handbook* for more information on getting care.

## G. Your care team and care plan

### G1. Care team

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

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

### G2. Care plan

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

Your care plan includes:

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They talk with you about services you need. They also tell you about services you may want to think about getting. Your care plan is based on your needs. Your care team works with you to update your care plan at least every year.

## H. Monthly plan premium

### H1. Plan premium

As a member of your plan, you pay a monthly plan premium. For 2023, the monthly Part D premium for Blue Shield TotalDual Plan is $38.90. However, you pay **$0** per month as long as you have Part D Low-Income Subsidy, also known as “Extra Help”, and full Medi-Cal coverage.

## I. Your *Member Handbook*

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

You can ask for a *Member Handbook* by calling Customer Care at the numbers at the bottom of the page. You can also refer to the *Member Handbook* on our website at the web address at the bottom of the page or download it.

The contract is in effect for the months you are enrolled in our plan between January 1, 2023 and December 31, 2023.

## J. Other important information you get from us

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

### J1. Your Plan ID Card

Under our plan, you have one card for your Medicare and Medi-Cal services covered by our plan, including long-term services and supports, certain behavioral health services, and prescriptions. You show this card when you get any services or Part D prescriptions. Here is a sample Member ID Card:


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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card. Keep this card in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Member Handbook* to find out what to do if you get a bill from a provider.

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

- Prescriptions only covered through Medi-Cal Rx
- Dental services only covered through the Medi-Cal Dental Program
- In-Home Supportive Services (IHSS)
- Multi*purpose Senior Services Program (MSSP)*

### J2. *Provider and Pharmacy Directory*

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

You can ask for a *Provider and Pharmacy Directory* by calling Customer Care at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

The *Provider and Pharmacy Directory* lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support Providers (such as Adult Day Health and Home Health Providers) that you may see as a Blue Shield TotalDual Plan or Blue Shield Promise Medi-Cal 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
- 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**

- Our network providers include:
    - Doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**

- LTSS, behavioral health services, home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

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

**Definition of network pharmacies**

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

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

## J3. *List of Covered Drugs*

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

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

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

## J4. The *Explanation of Benefits*

When you use your Part D prescription drug benefits, we 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, spent on your Part D prescription drugs and the total amount we 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** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

## K. Keeping your membership record up to date

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

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

Tell us right away about the following:

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

If any information changes, call Customer Care.

### K1. Privacy of protected health information (PHI)

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

# Chapter 2: Important phone numbers and resources

## Introduction

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

## Table of Contents

## A. Customer Care

| | |
|---|---|
| **CALL** | 1-800-452-4413 This call is free.<br>8:00 a.m. to 8:00 p.m., seven days a week<br>We have free interpreter services for people who do not speak English. |
| **TTY** | 711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>8:00 a.m. to 8:00 p.m., seven days a week. |
| **WRITE** | Blue Shield TotalDual Plan<br>P.O. Box 927, Woodland Hills, CA 91365-9856 |
| **WEBSITE** | blueshieldca.com/medicare |

Contact Customer Care to get help with:

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

- Appeals about your health care
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
    - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your health care
    - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint 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 at 1-800-452-4413.
    - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
    - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - You can make a complaint about our plan to the Ombuds Program by calling 1-888-804-3536.
    - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your Medicare covered drugs
    - A coverage decision about your Medicare drugs is a decision about:
        - your benefits and Medicare covered drugs **or**
        - the amount we pay for your Medicare drugs.
    - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273.
    - For more on coverage decisions about your Medicare prescription drugs, refer to **Chapter 9** of your *Member Handbook*.

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

## B. Your Care Coordinator

A Care Coordinator is a person specially trained to help you through the coordination of care process. Your Care Coordinator will be part of your Care Team, and he/she will serve as a primary contact for you. Upon enrolling, a Care Coordinator will call you to complete your Health Risk Assessment and Individualized Care Plan. These are tools that your Care Coordinator will use to help identify and personalize your health care needs to fit you. You can contact your Care Coordinator by calling the number below.

| | |
|---|---|
| **CALL** | 1-888-548-5765 This call is free.<br>8:00 a.m. to 6:00 p.m., Monday through Friday<br>We have free interpreter services for people who do not speak English. |

| | |
|---|---|
| **TTY** | 711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>8:00 a.m. to 6:00 p.m., Monday through Friday |
| **WRITE** | Blue Shield TotalDual Plan<br>P.O. Box 927, Woodland Hills, CA 91365-9856 |

Contact your care coordinator to get help with:

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

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 supports adults who need assistance 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 your Care Coordinator or Customer Care for a referral.

LTSS includes Community-Based Adult Services (CBAS), In-Home Supportive Services (IHSS), Multipurpose Senior Services Program (MSSP), and 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.

Depending on the county you live in and your eligibility, you may also receive additional Community Supports through your Blue Shield Promise Medi-Cal Plan. Your provider can refer you if they think you are eligible for Community Supports or you can reach out to Customer Care or your Care Coordinator to learn more. You might be able to get these services:

- Environmental accessibility adaptations (home modifications),
- Housing transition navigation services,
- Housing deposits,
- Housing tenancy and sustaining services,
- Supportive meals or medically tailored meals,
- Personal care and homemaker services,
- Recuperative care (medical respite),
- Respite for caregivers,
- Short-term post-hospitalization housing, or
- Sobering centers.

## C. Nurse Advice Call Line

The Blue Shield of California Nurse Advice Line offers support with registered nurses available to answer questions 24 hours a day, 7 days a week. 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. You can contact the Nurse Advice Call Line with questions about your health or health care.

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|---|---|
| **CALL** | (877) 304-0504 This call is free.<br>24 hours a day, seven days a week<br>We have free interpreter services for people who do not speak English. |
| **TTY** | 711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, seven days a week. |

## D. Behavioral Health Crisis Line

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|---|---|
| **CALL** | Los Angeles Access and Crisis Line<br>1-800-854-7771 *This call is free.*<br>24 hours a day, seven days a week.<br>We have free interpreter services for people who do not speak English.<br>San Diego Access and Crisis Line<br>1-888-724-7240 *This call is free.*<br>24 hours a day, seven days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | 711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, seven days a week |

Contact the Behavioral Health Crisis Line for help with:

- Questions about behavioral health and substance abuse services

- When you have questions about mental health and substance abuse disorder services, contact Blue Shield of California Promise Health Plan Behavioral Health Services at (855) 765-9701.

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

## E. 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.

| | |
|---|---|
| **CALL** | (800) 434-0222<br>9 a.m. to 4 p.m., Monday through Friday. |
| **TTY** | 711<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | California Department of Aging<br>1300 National Drive, Suite 200, Sacramento, CA 95834-1992 |
| **WEBSITE** | https://www.aging.ca.gov/Programs_and_Services/Medicare_Counseling/ |

Contact HICAP for help with:

- Questions about our plan or Medicare
- HICAP counselors can answer your questions about changing to a new plan and help you:
    - understand your rights,
    - understand your plan choices,
    - make complaints about your health care or treatment, **and**

- straighten out problems with your bills.

## F. Quality Improvement Organization (QIO)

Our state has an organization called 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.

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| **CALL** | 1-877-588-1123<br>8 a.m. to 5 p.m., Monday through Friday; 11 a.m. to 3 p.m., Saturday and Sunday; and 7 a.m. to 3:30 p.m. on holidays. |
| **TTY** | 1-855-887-6668<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WEBSITE** | https://livantaqio.com/en/states/california |

Contact Livanta Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) for help with:

- Questions about your health care rights
- 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.

## G. 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.

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| **CALL** | 1-800-MEDICARE (1-800-633-4227)<br>Calls to this number are free, 24 hours a day, 7 days a week. |
| **TTY** | 1-877-486-2048 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WEBSITE** | medicare.gov<br>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.<br>It includes helpful websites and phone numbers. It also has documents you can print right from your computer.<br>If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you. |

## H. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, foster care, pregnant women, and individuals with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed by state and federal government.

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| **CALL** | (800) 541-5555<br>Available 8:00 am to 5:00 pm, Monday through Friday. |

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|---|---|
| **TTY** | (800) 735-2922<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. |
| **WRITE** | CA Department of Health Care Services<br>Health Care Options<br>P.O. Box 997413, MS 4400<br>Sacramento, CA 95899-7413 |
| **WEBSITE** | www.dhcs.ca.gov |

## I. The Office of the Ombudsman

The Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Ombudsman can also help you with service or billing problems. The Office of the Ombudsman will not automatically take sides in a complaint. They consider all sides in an impartial and objective way. It is their job to help develop fair solutions to health care access problems. Their services are free.

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| **CALL** | 1-888-452-8609<br>This call is free. Monday through Friday, between 8:00 a.m. and 5:00 p.m. |
| **TTY** | 711<br>This call is free. |
| **WRITE** | California Department of Healthcare Services<br>Office of the Ombudsman<br>PO Box 997413, MS 4400<br>Sacramento, CA 95899-7413 |
| **EMAIL** | MMCDOmbudsmanOffice@dhcs.ca.gov |
| **WEBSITE** | www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx |

## J. County Social Services

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

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| **CALL** | 1-866-613-3777 This call is free.<br>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. |
| **TTY** | 1-877-735-2929<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | Los Angeles County Department of Public Social Services<br>2855 E. Olympic Blvd.<br>Los Angeles, CA 90023 |
| **WEBSITE** | https://dpss.lacounty.gov |
| **CALL** | 1-866-262-9881 This call is free.<br>County of San Diego Health and Human Services representatives are available between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.<br>Access Self-Service line is available 24 hours a day, 7 days a week. Callers will need to enter their Social Security Number (SSN) to utilize the system. |
| **TTY** | 1-619-589-4459<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |

| | |
|---|---|
| **WRITE** | County of San Diego<br>Health and Human Services Agency<br><br>PO Box 85027<br>San Diego, CA 92186 |
| **WEBSITE** | https://www.sandiegocounty.gov/content/sdc/hhsa.html |

## K. 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.

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| **CALL** | Los Angeles County<br>1-800-854-7771 This call is free.<br>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.<br>We have free interpreter services for people who do not speak English.<br><br>San Diego County<br>1-888-724-7240 This call is free.<br>24 hours a day, seven days a week.<br>We have free interpreter services for people who do not speak English. |
| **TTY** | 711 This call is free.<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.<br>24 hours a day, seven days a week. |

Contact the county specialty mental health plan for help with:

- 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

## L. California Department of Managed Health Care

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

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| **CALL** | 1-888-466-2219<br>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<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | Help Center<br>California Department of Managed Health Care<br>980 Ninth Street, Suite 500<br>Sacramento, CA 95814-2725 |
| **FAX** | 1-916-255-5241 |
| **WEBSITE** | **www.dmhc.ca.gov** |

## M. Other resources

The Health Consumer Alliance Ombuds Program (HCA) offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.

If you have problems with:

- Medi-Cal
- Medicare
- Your health plan
- Accessing medical services
- Appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- Medical billing
- IHSS (In-Home Supportive Services)

Health Consumer Alliance assists with complaints, appeals, and hearings. The phone number for the Health Consumer Alliance is 1-888-804-3536.

## How to contact the Los Angeles County and San Diego 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** | **Los Angeles**<br>1-888-202-4248<br>Monday through Friday, 8:00 a.m. to 5:00 p.m.<br><br>**San Diego**<br>1-800-510-2020<br>Monday through Friday, 8:00 a.m. to 5:00 p.m. |

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|---|---|
| **TTY** | 711<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | **Los Angeles County**<br>Los Angeles County Department of Workforce Development, Aging and Community Services<br>3175 W. 6th St.<br>Los Angeles, CA 90020<br><br>**San Diego County**<br>County of San Diego<br>Health and Human Services Agency<br><br>1600 Pacific Highway, Room 206<br>San Diego, CA 92101 |
| **WEBSITE** | **Los Angeles County**<br>https://css.lacounty.gov/<br>**San Diego County**<br>https://www.sandiegocounty.gov/content/sdc/hhsa/programs/ais/ |

## How to contact the Los Angeles County and San Diego 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.

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|---|---|
| **CALL** | **Los Angeles County**<br>1-916-654-1690<br>Monday through Friday, 8:00 a.m. to 5:00 p.m.<br>**San Diego County**<br>1-858-576-2996<br>Monday through Friday, 8:00 a.m. to 5:00 p.m. |
| **TTY** | **Los Angeles County**<br>1-916-654-2054<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | **Los Angeles County**<br>P.O. Box 944202<br>Sacramento, CA 94244-2020<br><br>**San Diego County**<br>San Diego Regional Center<br>4355 Ruffin Rd, Suite 200<br>San Diego, CA 92123 |
| **WEBSITE** | www.dds.ca.gov |

## 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.

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|---|---|
| **CALL** | 1-800-433-6251<br>Monday, Wednesday and Friday, 9:00 a.m. to 1:00 p.m. |
| **TTY** | 1-855-847-7914<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |

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|---|---|
| **WRITE** | Neighborhood Legal Services of Los Angeles County<br>13327 Van Nuys Boulevard<br>Pacoima, CA 91131<br>1104 E. Chevy Chase Drive<br>Glendale, CA 91205<br>3629 Santa Anita Avenue<br>El Monte, CA 91731 |
| **WEBSITE** | **www.nlsla.org** |

## How to contact the Legal Aid Society of San Diego

In addition to the Legal Aid Society of San Diego's (LASSD) health consumer center and Ombuds services program, LASSD also offers a full range of dynamic legal services. LASSD provides legal services in the areas of housing law (e.g., eviction defense, habitability, fair housing violations, etc.), family law (divorce, custody, visitation, and support disputes, etc.) immigration law (family-based petitions, U/T visas, etc.), consumer protection (collection defense, contractual disputes, etc.), and more.

| | |
|---|---|
| **CALL** | 1-877-534-2524<br>Monday through Friday, 9:00 a.m. to 5:00 p.m. |
| **TTY** | 1-800-735-2929<br>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. |
| **WRITE** | **Southeast San Diego Office**<br>110 S. Euclid Avenue<br>San Diego, CA 92114<br>**Midtown San Diego Office**<br>1764 San Diego Avenue, Suite 200<br>San Diego, CA 92110<br>**North County Office**<br>216 S. Tremont Street<br>Oceanside, CA 92054 |
| **WEBSITE** | **www.lassd.org** |

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

***Introduction***

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

## Table of Contents

## A. Information about services and providers

**Services** are health care (such as doctor visits and medical treatment), long-term services and supports (LTSS), supplies, behavioral health services (including mental health and wellness), 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 in **Chapter 4** *of your Member Handbook. Covered prescription and over-the-counter drugs are in* ***Chapter 5*** *of your Member Handbook.*

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

**Network providers** are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay *nothing* for covered services.

## B. Rules for getting services our plan covers

Our plan covers Medicare services and covers or coordinates all Medi-Cal services. This includes behavioral health and long-term services and supports (LTSS).

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

- The care you get must be a **plan benefit.** This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary.** By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another provider**.** 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 a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists.
    - Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is 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 (for more information about this, refer to section D1 in this chapter).

- **You must get your care from network providers that are affiliated with your PCP's medical group**. Usually, we won't cover care from a provider who doesn't work with our health plan and your PCP's medical group. This means that you will have to pay the provider in full for the services furnished from providers outside of the network. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information about this, refer to section H in the chapter.
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. An authorization is needed and should be obtained from the plan prior to seeking care. In this situation, we cover the care as if you got it from a network provider.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.
  - When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network that are affiliated with your PCP's medical group. After 12 months, we no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's medical group.

**New members to Blue Shield TotalDual Plan**: In most instances you will be enrolled in Blue Shield TotalDual Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in *Blue Shield TotalDual Plan*. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Blue Shield Promise Health Plan. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-452-4413 (TTY: 711) if you have any questions.

## C. Your care coordinator

### C1. What a care coordinator is

A care coordinator is a person specially trained to help you through the coordination of care process. Your care coordinator will be part of your care team and he/she will serve as a primary contact and source of information for you. After enrolling, a care coordinator will call you to introduce himself/herself and help you complete your Health Risk Assessment to identify your health care needs.

### C2. How you can contact your care coordinator

You can contact your care coordinator by calling 1-888-548-5765, 8:00 a.m. to 6:00 p.m., Monday through Friday. Once you begin working with a care coordinator, you can also contact him/her by calling their direct phone line.

### C3. How you can change your care coordinator

To request to change your care coordinator, you may call 1-888-548-5765, 8:00 a.m. to 6:00 p.m., Monday through Friday.

## D. Care from providers

### D1. Care from a primary care physician

You must choose a primary care physician (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 TotalDual 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
- 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.blueshieldca.com/medicare and search for the PCP you want; or
- Call Blue Shield TotalDual 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, or call Customer Care (phone number and hours of operation are printed on the bottom of this page).

If there is a particular Blue Shield TotalDual 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 blueshieldca.com/MAPDdocuments2023 or ask Blue Shield TotalDual 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 network, we can help you find a new PCP in 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. Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.

**Services you can get without approval from your PCP**

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

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

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

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Customer Care before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if 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, such as:

- Oncologists care for patients with cancer.
- Cardiologists care for patients with heart problems.
- Orthopedists care for patients with bone, joint, or muscle problems.
- 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. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We 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 work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to Chapter 9 *for more information.)*

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Please call Blue Shield TotalDual Plan Customer Care at 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. When you call, be sure to tell Customer Care if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Customer Care will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Customer Care will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect.

### D4. 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 unless you are receiving emergency or urgently needed

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

F. You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare. Our plan does not provide Medi-Cal covered behavioral health services, but these services are available to you through the Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH), and the County of San Diego Behavioral Health Services.

### G. E1. Medi-Cal behavioral health services provided outside our plan

H. Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by the Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH), and the County of San Diego Behavioral Health Services include:

- Mental health services
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention
- Crisis stabilization

- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management

Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through the Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH), and the County of San Diego Behavioral Health Services if you meet criteria to receive these services. Drug Medi-Cal services provided by the Los Angeles County Department of Mental Health (LACDMH) and the Los Angeles County Department of Public Health (LACDPH), and the County of San Diego Behavioral Health Services include:

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

Drug Medi-Cal Organized Delivery System Services include:

- Outpatient and intensive outpatient services
- Medications for addiction treatment (also called Medication Assisted Treatment)
- Residential/inpatient
- Withdrawal management
- Narcotic treatment services
- Recovery services
- Care coordination

In addition to the services listed above, you may have access to voluntary inpatient detoxification services if you meet the 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)
- County of San Diego Behavioral Health – Services Substance Use Disorder Service (please call 888-724-7240 (TTY: 711), 24 hours, seven days a week.)
- Blue Shield TotalDual Plan Behavioral Health Line (please see Chapter 2, Section D of this handbook for phone number and hours of operation)
- Blue Shield TotalDual 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 TotalDual 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 TotalDual Plan and the County

If you are receiving services from Blue Shield TotalDual Plan or the County, you can be referred to the other entity consistent with your needs. Blue Shield TotalDual 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.

Problem Resolution Process

If there is a dispute between you, and the County or Blue Shield TotalDual Plan, you will continue to receive medically necessary behavioral healthcare, including prescription drugs, until the dispute is resolved. Blue Shield TotalDual 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 TotalDual Plan or the County, depending upon the entity that you are in dispute with.

## F. Transportation services

### F1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need non-emergency medical transportation, you can contact Call The Car directly at 1-877-433-2178 (TTY: 711), 24 hours and 7 days a week or use the CTC Go mobile app to schedule, edit, track and cancel reservations. Non-urgent appointments, reservations must be made 24-hours in advance of your appointment. Your provider or our transportation vendor, Call The Car, can help you decide the best type of transportation to meet your needs.

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

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your other provider because you are not able to use a bus, taxi, car, or van to get to your appointment.

- You need help from the driver to and from your residence, vehicle, or place of treatment due to a physical or mental disability.

For **urgent appointments**, call as soon as possible. Urgent appointments do not require 24-hour advance notice. Urgent appointments include the following:

- Dialysis
- Discharge
- Follow-up to surgery
- Chemotherapy

- Radiation therapy
- Transfer hospital to hospital/SNF
- Wound care
- Urgent care centers

Have your Member ID Card ready when you call. You can also call if you need more information.

**Medical transportation limits**

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

## G2. Non-medical transportation

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

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

Blue Shield TotalDual Plan allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. Blue Shield TotalDual Plan uses Call the Car to arrange for non-medical transportation. We cover the lowest cost, non-medical transportation type that meets your needs.

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. Blue Shield TotalDual Plan must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You cannot be reimbursed for driving yourself**.

Mileage reimbursement requires all of the following:

- The driver's license of the driver
- The vehicle registration of the driver

- Proof of car insurance for the driver

To ask for a ride, contact Call the Car at 1-877-433-2178 (TTY: 711), 24 hours and 7 days a week at least twenty-four (24) hours in advance (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

**Note:** American Indians may contact their local Indian Health Clinic to ask for non-medical transportation.

**Non-medical transportation limits**

Blue Shield TotalDual Plan provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

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

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

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

### G1. Care in a medical emergency

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

- Serious risk to your health or to that of your unborn child; **or**
- Serious harm to bodily functions; **or**
- Serious dysfunction of any bodily organ or part; **or**

- In the case of a pregnant woman in active labor, when:
    - there is not enough time to safely transfer you to another hospital before delivery.
    - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We will follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay in telling us. Call Blue Shield TotalDual Plan Customer Care at 1-800-452-4413, 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**

In 2023, Blue Shield TotalDual 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.

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** *of your Member Handbook.*

Our plan covers worldwide emergency and urgent care services outside the United States and its territories under the following circumstances, with no combined annual limit. See "Emergency care" and "Urgently needed services" in the Medical Benefits Chart in Chapter 4 of this document for more information on how much you pay.

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

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

### Getting emergency care if it wasn't an emergency

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

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

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules (refer to Section H2) for getting it.

## G2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

### Urgently needed care in our plan's service area

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

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

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

### Urgently needed care outside our plan's service area

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

Blue Shield TotalDual 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.

If you need urgent care while outside of the United States and its territories, call the Blue Shield Global Core Services Center toll-free at **(800) 810-2583,** or call collect at (804)

673-1177, 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. You should also call the Customer Care number on the back of your member ID card. As part of this service, for inpatient hospital care, you can contact the Blue Shield Global Core Services Center to arrange for cashless access. If you arrange for cashless access, you are responsible for the usual out-of-pocket expenses such as non-covered charges and copayments. If you do not arrange for cashless access, you will have to pay the entire bill for your medical care and submit a request for reimbursement (see Chapter 2, *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received.*

### G3. 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 our plan.

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

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

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

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

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

If you paid for your covered services **or** if you paid more than your plan cost-sharing for covered services or if you got a bill for the full cost of covered medical services, refer to **Chapter 7** *of your Member Handbook* to find out what to do.

### H1. What to do if our plan does not cover services

Our plan covers all services:

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

- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

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

We pay for some services up to a certain limit. If you use over the limit, you pay the full cost to get more of that type of service. Call Customer Care to find out what the benefit limits are and how much of your benefits you've used.

## I. Coverage services in a clinical research study

### I1. Definition of a clinical research study

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

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

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

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

Your Blue Shield Promise Medi-Cal Plan covers routine patient care costs for patients accepted into Phase I, Phase II, Phase III or Phase IV clinical trials if it is related to the prevention, detection or treatment of cancer or other life-threatening conditions and if the study is conducted by the U.S. Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC) or Centers for Medicare and Medicaid Services (CMS). Studies must be approved by the National Institutes of Health, the FDA, the Department of Defense or the Veterans Administration.

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

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

### I2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

### I3. 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.

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

### J1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution. This benefit is only for Medicare Part A inpatient services (non-medical health care services).

### J2. Care from a religious non-medical health care institution

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

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

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

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

## K. Durable medical equipment (DME)

### K1. DME as a member of our plan

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you usually will **not** own DME, no matter how long you rent it.

In certain situations, Blue Shield TotalDual 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.

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

### K2. DME ownership if you switch to Original Medicare

If you didn't get ownership of the DME item while in our plan, you must make 13 new consecutive payments after you switch to Original Medicare to own the item. Payments you made while in our plan do **not** count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare **before** you joined our plan, your previous payments don't count toward the 13 consecutive payments. You must make 13 new consecutive payments after you return to Original Medicare to own the item. There are no exceptions to this case when you return to Original Medicare.

### K3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

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

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

### K4. Oxygen equipment when you switch to Original Medicare

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

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

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

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

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

# Chapter 4: Benefits chart

***Introduction***

This chapter tells you about the services *our 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 your *Member Handbook*.

**New members to** Blue Shield TotalDual Plan**:** In most instances you will be enrolled in Blue Shield TotalDual Plan for your Medicare benefits the 1st day of the month after you request to be enrolled in Blue Shield TotalDual Plan. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through Blue Shield Promise Medi-Cal Plan. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-452-4413 (TTY: 711) if you have any questions.

## Table of Contents

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

This chapter tells you about services our plan covers and 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**. This chapter also explains limits on some services.

For some services, you are 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 coordinator and/or Customer Care at 1-800-452-4413 (TTY: 711).

## B. Rules against providers charging you for services

We don't allow our in-network 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** of your *Member Handbook* or call Customer Care.

## C. About our plan's Benefits Chart

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

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

- We must provide your Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. A service is medically necessary when it is responable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate sever pain.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we do **not** pay for care you get from an out-of-network provider. **Chapter 3** of your Member Handbook has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of your Member Handbook has more information about getting a referral and when you do **not** need one.
- You must get care from providers that are affiliated with your PCP's medical group. Refer to **Chapter 3** of your Member Handbook for more information..
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization. We mark covered services in the Benefits Chart that need prior authorization in italic type.
- If you are within our plan's six-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Blue Shield TotalDual Plan will not cover Medi-Cal (Medicaid) benefits that are included under Medi-Cal (Medicaid), nor will we pay the Medicare premiums or cost sharing for which the State would otherwise be liable had you not lost your Medi-Cal (Medicaid) eligibility. The amount you pay for your Medicare-covered services in this plan may increase during the period after you lose Medi-Cal (Medicaid) eligibility.
- All preventive services are free. You find this apple next to preventive services in the Benefits Chart.
- **Community Supports**: Community Supports may be available under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings. These services are optional for members. If you qualify, these services may help you live more independently. They do not replace benefits that you already get under Medi-Cal. Examples of Community Supports that we offer include medically-supportive food and meals or medically-tailored meals, help for you or your caregiver, or shower grab bars and ramps. Examples of Community Supports services that Blue Shield TotalDual 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

which Community Supports may be available for you, call your care coordinator or call your health care provider.

## D. Our plan's Benefits Chart

| Services that our plan pays for | | What you must pay |
|---|---|---|
|  | **Abdominal aortic aneurysm screening**<br><br>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Acupuncture (Medicare and Medi-Cal Covered)**<br><br>We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.<br><br>We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:<br>• lasting 12 weeks or longer;<br>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);<br>• not associated with surgery; **and**<br>• not associated with pregnancy.<br><br>In addition, we 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.<br><br>Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.<br><br>Provider Requirements:<br>Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act) may furnish acupuncture in accordance with applicable state requirements.<br>Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:<br>• a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,<br>• a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia.<br><br>**This benefit is continued on the next page** | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Acupuncture (continued)**<br>Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.<br><br>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 pm. You can also call Blue Shield TotalDual Plan Customer Care or go to blueshieldca.com/find-a-doctor to locate an ASH Plans participating provider. | |
| | **Acupuncture services (non-Medicare covered)**<br>Benefits are provided for acupuncture evaluation and treatment by a Doctor of Medicine, licensed acupuncturist, or other appropriately licensed or certified Health Care Provider.<br>• Initial and subsequent examinations<br>• Office visits and adjustments<br>• Adjunctive therapies<br><br>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 TotalDual Plan Customer Care or go to **blueshieldca.com/find-a-doctor** to locate an ASH Plans participating provider.<br><br>*Services do not apply to the plan's maximum out-of-pocket limit. | You pay $0<br>(limited to up to 12 visits per year). |

| Services that our plan pays for | | What you must pay |
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| | **Additional telehealth services**<br>Teladoc provides Physician consultations by phone or online. 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 (1-800-835-2362) [TTY: 711], 24 hours a day, 7 days a week, 365 days a year.<br><br>* Services do not apply to the plan's maximum out-of-pocket limit. | $0 |
| | **Alcohol misuse screening and counseling**<br>We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.<br>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. | $0 |
| | **Ambulance services**<br>Covered ambulance services include ground, fixed-wing, and rotary-wing (helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care.<br>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.<br>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. | $0 |

| | Services that our plan pays for | What you must pay |
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| | **Annual physical exam**<br>You are covered for one routine physical exam every 12 months in addition to your 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. | $0 |
| | **Annual wellness visit**<br>You should get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.<br>Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months. | $0 |
| | **Asthma Preventive Serivces**<br>You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma. | $0 |
| | **Bone mass measurement**<br>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.<br>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results. | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Breast cancer screening (mammograms)**<br><br>We pay for the following services:<br>• One baseline mammogram between the ages of 35 and 39<br>• One screening mammogram every 12 months for women age 40 and older<br>• Clinical breast exams once every 24 months | $0 |
| | **Cardiac (heart) rehabilitation services**<br><br>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's *referral*.<br><br>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. | $0 |
| | **Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)**<br><br>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, your doctor may:<br>• Discuss aspirin use,<br>• Check your blood pressure, **and/or**<br>• Give you tips to make sure you are eating well. | $0 |

| Services that our plan pays for | | What you must pay |
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|  | **Cardiovascular (heart) disease testing**<br><br>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. | $0 |
|  | **Cervical and vaginal cancer screening**<br><br>We pay for the following services:<br>• For all women: Pap tests and pelvic exams once every 24 months<br>• For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months<br>• 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<br>• 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 |
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| | **Chiropractic services**<br><br>We pay for the following services:<br>• Adjustments of the spine to correct alignment<br><br>• Initial and subsequent examinations<br>• Office visits and chiropractic adjustments<br>• Adjunctive therapies<br>• X-rays and laboratory tests (chiropractic only)<br><br>Benefits are provider 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 pm. You can also call Blue Shield TotalDual Plan Customer Care or go to **blueshieldca.com/find-a-doctor** to locate an ASH Plans participating provider**.**<br><br>* Services do not apply to the plan's maximum out-of-pocket limit. | $0<br><br>$0 (coverage is limited to up to 12 visits per year for non-Medicare covered services). |
| | **Colorectal cancer screening**<br><br>For people 50 and older, we pay for the following services:<br>• Flexible sigmoidoscopy (or screening barium enema) every 48 months<br>• Fecal occult blood test, every 12 months<br>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months<br>• DNA based colorectal screening, every 3 years<br>• Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)<br>• Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months. | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Community Based Adult Services (CBAS)**<br><br>CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We pay for CBAS if you meet the eligibility criteria.<br><br>**Note:** If a CBAS facility is not available, we can provide these services separately. | $0 |
| | **Counseling to stop smoking or tobacco use**<br><br>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:<br>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.<br><br>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:<br>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.<br><br>If you are pregnant, you may get unlimited tobacco cessation counseling with prior authorization. | $0 |

| | Services that our plan pays for | What you must pay |
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| | **Dental services**<br><br>Certain dental services, including but not limited to, cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program or FFS Medi-Cal.<br><br>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover some routine and comprehensive dental services:<br><br>For a list of covered dental procedures, see the *Routine Dental Benefits Procedure Chart* at the end of the Medical Benefits Chart for more information on how to access these services.<br><br>The copayments listed in the *Routine Dental Benefits Procedure Chart* apply to services only when prescribed by a network dentist as a necessary, adequate and appropriate procedure for your dental condition.<br><br>Not all benefits may be appropriate for everyone. You should rely on your network dentist to determine the appropriate care for you. The dental provider network is a general dentist network only; there are no specialists in the network.<br><br>* Services do not apply to the plan's maximum out-of-pocket limit. | See the *Routine Dental Benefits Procedure Chart* at the end of the Medical Benefits Chart for a list of the covered dental procedures and what you pay. |
| | **Depression screening**<br><br>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. | $0 |

| Services that our plan pays for | | What you must pay |
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|  | **Diabetes screening**<br><br>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:<br>• High blood pressure (hypertension)<br>• History of abnormal cholesterol and triglyceride levels (dyslipidemia)<br>• Obesity<br>• History of high blood sugar (glucose)<br><br>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.<br><br>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months. | $0 |

| Services that our plan pays for | What you must pay |
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| **Diabetic self-management training, services, and supplies**<br><br>We pay for the following services for all people who have diabetes (whether they use insulin or not):<br>• Supplies to monitor your blood glucose, including the following:<br>  ○ A blood glucose monitor<br>  ○ Blood glucose test strips<br>  ○ Lancet devices and lancets<br>  ○ Glucose-control solutions for checking the accuracy of test strips and monitors<br>• For people with diabetes who have severe diabetic foot disease, we pay for the following:<br>  ○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or**<br>  ○ 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)<br><br>In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customare Care.<br><br>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. | $0<br>• For blood glucose monitors, please see the Durable Medical Equipment (DME) and related supplies section below. |

| Services that our plan pays for | | What you must pay |
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| | **Doula Services**<br><br>For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery. | $0 |
| | **Durable medical equipment (DME) and related supplies**<br><br>Refer to the last chapter of your *Member Handbook* for a definition of "Durable medical equipment (DME)."<br><br>We cover the following items:<br>• Wheelchairs, including electric wheelchairs<br>• Crutches<br>• Powered mattress systems<br>• Dry pressure pad for mattress<br>• Diabetic supplies<br>• Hospital beds ordered by a provider for use in the home<br>• Intravenous (IV) infusion pumps and pole<br>• Enteral pump and supplies<br>• Speech generating devices<br>• Oxygen equipment and supplies<br>• Nebulizers<br>• Walkers<br>• Standard curved handle or quad cane and replacement supplies<br>• Cervical traction (over the door)<br>• Bone stimulator<br>• Dialysis care equipment<br><br>Other items may be covered.<br><br>**This benefit is continued on the next page** | Blood glucose monitors:<br><br>• You pay $0 for FreeStyle® blood glucose monitors.<br>• To obtain, blood glucose monitors from all other manufacturers at $0, show your provider or pharmacist both your Blue Shield TotalDual Plan and Medi-Cal Beneficiary ID cards. |

| Services that our plan pays for | | What you must pay |
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| | **Durable medical equipment (DME) and related supplies (continued)**<br><br>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. Authorization rules may apply.<br><br>*Durable medical equipment will require approval in advance (sometimes called "prior authorization") from us if you or your provider want to request durable medical equipment provided by a non-preferred supplier.* | |

| Services that our plan pays for | | What you must pay |
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| | **Emergency care**<br><br>Emergency care means services that are:<br>• Given by a provider trained to give emergency services, **and**<br>• Needed to treat a medical emergency.<br><br>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:<br>• Serious risk to your health or to that of your unborn child; **or**<br>• Serious harm to bodily functions; **or**<br>• Serious dysfunction of any bodily organ or part; **or**<br>• In the case of a pregnant woman in active labor, when:<br>  ○ There is not enough time to safely transfer you to another hospital before delivery.<br>  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.<br><br>Worldwide coverage.*<br>You have no combined annual limit for emergency care or urgently needed services outside the United States every year.<br><br>*Services outside the United States and its territories do not apply to the plan's maximum out-of-pocket limit. | $0<br><br>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital 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. |

| Services that our plan pays for | | What you must pay |
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| | **Family planning services**<br><br>The law lets you choose any provider for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.<br><br>We pay for the following services:<br>• Family planning exam and medical treatment<br>• Family planning lab and diagnostic tests<br>• Family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)<br>• Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)<br>• Counseling and diagnosis of infertility and related services<br>• Counseling, testing, and treatment for sexually transmitted infections (STIs)<br>• Counseling and testing for HIV and AIDS, and other HIV-related conditions<br>• 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.)<br>• Genetic counseling<br><br>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:<br>• Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)<br>• Treatment for AIDS and other HIV-related conditions<br>• Genetic testing | $0 |

| Services that our plan pays for | What you must pay |
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| **Health and wellness education programs*** | |
| We offer many programs that focus on certain health conditions. These include:<br>• Health Education classes;<br>• Nutrition Education classes;<br>• Smoking and Tobacco Use Cessation; **and**<br>• Nursing Hotline | $0 for written health education materials, including newsletters. |
| Programs to help you stay healthy. Covered services include:<br>• Written health education materials, including newsletters<br>• Educational programs<br>• Educational Programs that focus on health conditions such as:<br>  ○ High blood pressure<br>  ○ Cholesterol<br>  ○ Asthma<br>  ○ Special diet<br>• Educational Programs designed to enrich your health and lifestyle, including:<br>  ○ Weight management<br>  ○ Fitness<br>  ○ Stress management | $0 for educational programs provided by a plan-approved location. |
| **NurseHelp 24/7**<br>Have a confidential one-on-one online dialogue with a registered nurse, 24 hours a day. When you have a medical concern, one call to our toll-free hotline puts you in touch with a registered nurse who will listen to your concerns and help you toward a solution.<br>Call 1-877-304-0504 (TTY: 711)<br>24 hours a day, 7 days a week.<br>**This benefit is continued on the next page** | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Health and wellness education programs (continued)*** **SilverSneakers® Fitness** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, mall and parks). SilverSneakers also connects you to a support network and virtual classes through SilverSneakers LIVE™, SilverSneakers On-Demand™ videos and our mobile app, SilverSneakers GO™. You also get access to Stitch[3], an online social site for seniors, where you can join in-person and online activities and events. All you need to get started is your personal SilverSneakers ID number. Go to Silversneakers.com to learn more about your benefit or call 1-888-423-4632 [TTY: 711] Monday through Friday, 8 a.m. to 8 p.m. ET.<br><br>**Always talk with your doctor before starting an exercise program.**<br><br>[1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL.<br><br>[2]Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location.<br><br>[3]Stitch is a third-party provider and is not owned or operated by Tivity Health or its affiliates. SilverSneakers<br><br>**This benefit is continued on the next page** | $0 |

| Services that our plan pays for | | What you must pay |
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|  | **Health and wellness education programs (continued)*** members must have internet service to access Stitch service. Internet service charges are the responsibility of the SilverSneakers member.<br><br>**Personal Emergency Response System (PERS)** – a medical alert monitoring system that provides access to help 24/7, at the push of a button. Your PERS benefits are provided by LifeStation® and include:<br>• One personal emergency response system<br>• Choice of an in-home system or mobile device with GPS/WiFi<br>• Monthly monitoring<br>• Necessary chargers and cords<br><br>To obtain the PERS and begin receiving services, call LifeStation's team 24/7 at 1-855-672-3269 (TTY:711) or visit **blueshieldca.com/PERS.**<br><br>* Services do not apply to the plan's maximum out-of-pocket limit. | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Hearing services**<br><br>Diagnostic hearing and balance evaluations performed by your PCP to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.<br><br>• Routine (non-Medicare covered) hearing exams (requires prior approval from your PCP).*<br><br>• Hearing aids*<br><br>• * Services do not apply to the plan's maximum out-of-pocket limit. | • You pay $0 for Medicare-covered diagnostic hearing exams.<br>• You pay $0 for one routine hearing exam per year.<br>• You pay $0 for hearing aid fitting/evaluation.<br>• You pay $0 for 2 hearing aids (all types, both ears combined) priced up to $2,000 every year. If you choose hearing aids priced above $2,000, you are responsible for the difference. |
| | **HIV screening**<br><br>We pay for one HIV screening exam every 12 months for people who:<br>• Ask for an HIV screening test, **or**<br>• Are at increased risk for HIV infection.<br><br>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.<br><br>We also pay for additional HIV screening(s) when recommended by your provider. | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Home health agency care**<br><br>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.<br><br>We pay for the following services, and maybe other services not listed here:<br>• 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.)<br>• Physical therapy, occupational therapy, and speech therapy<br>• Medical and social services<br>• Medical equipment and supplies | $0 for each covered home health visit. |

| Services that our plan pays for | | What you must pay |
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| | **Home infusion therapy**<br><br>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:<br>• The drug or biological substance, such as an antiviral or immune globulin;<br>• Equipment, such as a pump; **and**<br>• Supplies, such as tubing or a catheter.<br><br>Our plan covers home infusion services that include but are not limited to:<br>• Professional services, including nursing services, provided in accordance with your care plan;<br>• Member training and education not already included in the DME benefit;<br>• Remote monitoring; **and**<br>• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. | $0 for each covered home infusion therapy visit. |
| | **Home meal delivery**<br><br>Upon discharge from an inpatient hospital or skilled nursing facility stay, we cover:<br><br>• 22 meals and 10 snacks per discharge<br>• Meals and snacks will be divided into up to three separate deliveries as needed<br>• Coverage is limited to two discharges per year<br>For more information, call Blue Shield TotalDual Plan Customer Care (phone numbers are printed on the back cover of this document).<br><br>* Services do not apply to the plan's maximum out-of-pocket limit | $0 for each covered home meal delivery. |

| Services that our plan pays for | | What you must pay |
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| | **Hospice care**<br><br>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.<br><br>Our plan pays for the following while you get hospice services:<br>• Drugs to treat symptoms and pain<br>• Short-term respite care<br>• Home care<br><br>**Hospice services and services covered by Medicare Part A or B are billed to Medicare.**<br>• Refer to **Section F** of this chapter for more information.<br><br>**For services covered by our plan but not covered by Medicare Part A or B:**<br>• Our plan covers services not covered under Medicare Part A or B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing *for* these services.<br><br>**For drugs that may be covered by our plan's Medicare Part D benefit:**<br>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** *of your Member Handbook*.<br><br>**This benefit is continued on the next page** | $0 |

| Services that our plan pays for | | What you must pay |
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| | **Hospice care (continued)**<br><br>**Note:** If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis.<br><br>***Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.*** | |
| | **Immunizations**<br><br>We pay for the following services:<br>• Pneumonia vaccine<br>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary<br>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B<br>• COVID-19 vaccines<br>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules<br><br>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your Member Handbook to learn more.<br><br>We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP). | $0 for Medicare Part B-covered immunization. |

| | Services that our plan pays for | What you must pay |
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| | **Inpatient hospital care**<br><br>We pay for the following services and other medically necessary services not listed here:<br>• Semi-private room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Regular nursing services<br>• Costs of special care units, such as intensive care or coronary care units<br>• Drugs and medications<br>• Lab tests<br>• X-rays and other radiology services<br>• Needed surgical and medical supplies<br>• Appliances, such as wheelchairs<br>• Operating and recovery room services<br>• Physical, occupational, and speech therapy<br>• Inpatient substance abuse services<br>• In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.<br>• If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If Blue Shield TotalDual Plan provides transplant services at a location outside the pattern<br><br>**This benefit is continued on the next page** | $0<br><br>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized. |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Inpatient hospital care (continued)**<br>• of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. †<br>• Blood, including storage and administration<br>• Physician services<br>**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.<br>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.<br>†Transplants are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. | |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Inpatient services in a psychiatric hospital**<br><br>We pay for mental health care services that require a hospital stay.<br><br>• If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency.<br>  ○ The 190-day limit does **not** apply to inpatient mental health services provided in a psychiatric unit of a general hospital.<br>• If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD). | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay**<br><br>We do not pay for your inpatient stay if it is not reasonable and medically necessary.<br><br>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Customer Care.<br><br>We pay for the following services, and maybe other services not listed here:<br>• Doctor services<br>• Diagnostic tests, like lab tests<br>• X-ray, radium, and isotope therapy, including technician materials and services<br>• Surgical dressings<br>• Splints, casts, and other devices used for fractures and dislocations<br>• Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of:<br>o An internal body organ (including contiguous tissue), **or**<br>o The function of an inoperative or malfunctioning internal body organ.<br>• Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition<br>• Physical therapy, speech therapy, and occupational therapy | $0 |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Kidney disease services and supplies**<br><br>We pay for the following services:<br>• Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services.<br>• Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Member Handbook*, or when your provider for this service is temporarily unavailable or inaccessible.<br>• Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care<br>• Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments<br>• Home dialysis equipment and supplies<br>• 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.<br><br>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Lung cancer screening**<br><br>Our plan pays for lung cancer screening every 12 months if you:<br>• Are aged 50-77, **and**<br>• Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and**<br>• 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.<br><br>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider. | $0 |
| | **Medical nutrition therapy**<br><br>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.<br><br>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.<br><br>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's*referral*. A doctor must prescribe these services and renew the *referral* each year if you need treatment in the next calendar year. We may approve additional services if medically necessary. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Medicare Diabetes Prevention Program (MDPP)**<br><br>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:<br>• Long-term dietary change, **and**<br>• Increased physical activity, **and**<br>• Ways to maintain weight loss and a healthy lifestyle. | $0 |
| | **Medicare Part B prescription drugs**<br><br>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:<br>• Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services<br>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized<br>• Clotting factors you give yourself by injection if you have hemophilia<br>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant<br>• Osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself<br>• Antigens<br>• Certain oral anti-cancer drugs and anti-nausea drugs<br><br>**This benefit is continued on the next page** | $0 (Please provide your doctor or pharmacy both your Blue Shield TotalDual Plan ID Card and your Medical Benefits Identification Card) |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Medicare Part B prescription drugs (continued)**<br>• Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)<br>• IV immune globulin for the home treatment of primary immune deficiency diseases<br>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.<br>**Chapter 5** of your Member Handbook explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.<br>**Chapter 6** of your Member Handbook explains what you pay for your outpatient prescription drugs through our plan. | |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Nursing facility care**<br><br>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.<br><br>Services that we pay for include, but are not limited to, the following:<br>• Semiprivate room (or a private room if medically necessary)<br>• Meals, including special diets<br>• Nursing services<br>• Physical therapy, occupational therapy, and speech therapy<br>• Respiratory therapy<br>• 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.)<br>• Blood, including storage and administration<br>• Medical and surgical supplies usually given by nursing facilities<br>• Lab tests usually given by nursing facilities<br>• X-rays and other radiology services usually given by nursing facilities<br>• Use of appliances, such as wheelchairs usually given by nursing facilities<br>• Physician/practitioner services<br>• Durable medical equipment<br>• Dental services, including dentures<br>• Vision benefits<br><br>**This benefit is continued on the next page** | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Nursing facility care (continued)**<br>• Hearing exams<br>• Chiropractic care<br>• Podiatry services<br>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:<br>• 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).<br>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital. | |
| | **Obesity screening and therapy to keep weight down**<br>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Opioid treatment program (OTP) services**<br>Our plan pays for the following services to treat opioid use disorder (OUD):<br>• Intake activities<br>• Periodic assessments<br>• Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications<br>• Substance use counseling<br>• Individual and group therapy<br>• Testing for drugs or chemicals in your body (toxicology testing) | $0 |
| | **Outpatient diagnostic tests and therapeutic services and supplies**<br>We pay for the following services and other medically necessary services not listed here:<br>• X-rays<br>• Radiation (radium and isotope) therapy, including technician materials and supplies<br>• Surgical supplies, such as dressings<br>• Splints, casts, and other devices used for fractures and dislocations<br>• Lab tests<br>• Blood, including storage and administration<br>• Other outpatient diagnostic tests<br>*Authorization rules may apply for services. You should talk to your provider and get a referral.* | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Outpatient hospital services**<br><br>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:<br>• Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services<br>  ○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”<br>  ○ Sometimes you can be in the hospital overnight and still be “outpatient.”<br>  ○ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/media/11101<br>• Labs and diagnostic tests billed by the hospital<br>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it<br>• X-rays and other radiology services billed by the hospital<br>• Medical supplies, such as splints and casts<br>• Preventive screenings and services listed throughout the Benefits Chart<br>• Some drugs that you can’t give yourself<br>**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.<br><br>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have<br>**This benefit is continued on the next page** | $0 |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Outpatient hospital services (continued)**<br><br>Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.<br>*Authorization rules may apply for services.*<br>*You should talk to your provider and get a referral.* | |
| | **Outpatient mental health care**<br><br>We pay for mental health services provided by:<br>• A state-licensed psychiatrist or doctor<br>• A clinical psychologist<br>• A clinical social worker<br>• A clinical nurse specialist<br>• A nurse practitioner<br>• A physician assistant<br>• Any other Medicare-qualified mental health care professional as allowed under applicable state laws<br>We pay for the following services, and maybe other services not listed here:<br>• Clinic services<br>• Day treatment<br>• Psychosocial rehab services<br>• Partial hospitalization or Intensive outpatient programs<br>• Individual and group mental health evaluation and treatment<br>• Psychological testing when clinically indicated to evaluate a mental health outcome<br>**This benefit is continued on the next page** | $0 for each individual or group therapy visit. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Outpatient mental health care (continued)**<br>• Outpatient services for the purposes of monitoring drug therapy<br>• Outpatient laboratory, drugs, supplies and supplements<br>• Psychiatric consultation | |
| | **Outpatient rehabilitation services**<br>We pay for physical therapy, occupational therapy, and speech therapy.<br>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. | $0 |
| | **Outpatient substance abuse services**<br>We pay for the following services, and maybe other services not listed here:<br>• Alcohol misuse screening and counseling<br>• Treatment of drug abuse<br>• Group or individual counseling by a qualified clinician<br>• Subacute detoxification in a residential addiction program<br>• Alcohol and/or drug services in an intensive outpatient treatment center<br>• Extended release Naltrexone (vivitrol) treatment | $0 for each individual or group therapy visit. |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Outpatient surgery**<br><br>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.<br><br>**Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient." | $0 for each visit to an ambulatory surgical center and outpatient hospital facility. |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Over-the-Counter (OTC) Items**<br><br>You are entitled to a quarterly allowance of $210 for OTC drugs and supplies listed in the OTC catalog. 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.<br><br>The OTC catalog and ordering instructions are available online at blueshieldca.com/medicareOTC. You can order items by phone at (888) 628-2770 [TTY: 711], Monday to Friday between 9 a.m. and 5 p.m. or online at blueshieldca.com/medicareOTC. Orders will be shipped to you at no extra charge. Please allow approximately 14 business days for delivery.<br><br>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.<br>Some limitations apply. Refer to the OTC Catalog for more information.<br><br>* Services do not apply to the plan's maximum out-of-pocket limit. | $0 |
| | **Partial hospitalization services**<br><br>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.<br><br>***Note:*** *Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.* | $0 |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Physician/provider services, including doctor's office visits**<br><br>We pay for the following services:<br>• Medically necessary health care or surgery services given in places such as:<br>  ○ Physician's office<br>  ○ Certified ambulatory surgical center<br>  ○ Hospital outpatient department<br>• Consultation, diagnosis, and treatment by a specialist<br>• Basic hearing and balance exams given by your *primary care provider*, if your doctor orders them to find out whether you need treatment<br><br>Certain telehealth services, including physician's services to treat non-emergency conditions such as cold and flu symptoms, allergies, bronchitis, respiratory infection, sinus problems, rash, eye infection, migraine and more.<br>  ○ 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.<br>  ○ Refer to the "Additional telehealth services" section in the Medical Benefits Chart for more information.<br>• Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home<br><br>**This benefit is continued on the next page** | $0 |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Physician/provider services, including doctor's office visits (continued)**<br>• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke<br>• Telehealth services for members with a substance use disorder or co-occurring mental health disorder<br>• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:<br>  ○ You have an in-person visit within 6 months prior to your first telehealth visit<br>  ○ You have an in-person visit every 12 months while receiving these telehealth services<br>  ○ Exceptions can be made to the above for certain circumstances<br>• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.<br>• Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**<br>  ○ You're not a new patient **and**<br>  ○ The check-in isn't related to an office visit in the past 7 days **and**<br>  ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours **if**<br>  ○ You're not a new patient **and**<br>**This benefit is continued on the next page** | |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Physician/provider services, including doctor's office visits (continued)**<br>○ The evaluation isn't related to an office visit in the past 7 days **and**<br>○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment<br>• Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient<br>• Second opinion *by another network provider* before surgery<br>• Non-routine dental care. Covered services are limited to:<br>○ Surgery of the jaw or related structures<br>○ Setting fractures of the jaw or facial bones<br>○ Pulling teeth before radiation treatments of neoplastic cancer<br>○ Services that would be covered when provided by a physician | |
| | **Podiatry services**<br>We pay for the following services:<br>• Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)<br>• Routine foot care for members with conditions affecting the legs, such as diabetes<br>• Routine (non-Medicare covered) foot care* | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
|  | **Prostate cancer screening exams**<br><br>For men age 50 and older, we pay for the following services once every 12 months:<br>• A digital rectal exam<br>• A prostate specific antigen (PSA) test | $0 |
| | **Prosthetic devices and related supplies**<br><br>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:<br>• Colostomy bags and supplies related to colostomy care<br>• Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections<br>• Pacemakers<br>• Braces<br>• Prosthetic shoes<br>• Artificial arms and legs<br>• Breast prostheses (including a surgical brassiere after a mastectomy)<br>• Prostheses to replace all of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect<br>• Incontinence cream and diapers<br><br>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.<br><br>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Pulmonary rehabilitation services**<br><br>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral for pulmonary rehabilitation from the doctor or provider treating the COPD.<br><br>We pay for respiratory services for ventilator-dependent patients. | $0 |
| | **Sexually transmitted infections (STIs) screening and counseling**<br><br>We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy.<br><br>We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Skilled nursing facility (SNF) care**<br><br>We pay for the following services, and maybe other services not listed here:<br>• A semi-private room, or a private room if it is medically necessary<br>• Meals, including special diets<br>• Nursing services<br>• Physical therapy, occupational therapy, and speech therapy<br>• Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors<br>• Blood, including storage and administration<br>• Medical and surgical supplies given by nursing facilities<br>• Lab tests given by nursing facilities<br>• X-rays and other radiology services given by nursing facilities<br>• Appliances, such as wheelchairs, usually given by nursing facilities<br>• Physician/provider services<br><br>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:<br>• 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)<br>• A nursing facility where your spouse or domestic partner lives at the time you leave the hospital | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Supervised exercise therapy (SET)**<br><br>We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment.<br><br>Our plan pays for:<br>• Up to 36 sessions during a 12-week period if all SET requirements are met<br>• An additional 36 sessions over time if deemed medically necessary by a health care provider<br><br>The SET program must be:<br>• 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)<br>• In a hospital outpatient setting or in a physician's office<br>• Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD<br>• Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques<br><br>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Transportation: Non-emergency medical transportation**<br><br>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.<br><br>The forms of transportation are authorized when:<br><br>• 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**<br><br>Depending on the service, prior authorization may be required.<br><br>**Note**: Arrangements for transportation are handled by Call the Car. Members must contact Call the Car at (855) 200-7544 [TTY: 711] 24 hours a day, seven days a week. Arrangements for transportation must be made at least 24 hours in advance.<br><br>Call the Car offers a mobile application (CTC-Go) that can be used by Blue Shield TotalDual Plan members to coordinate healthcare transportation. CTC-Go allows you to review upcoming or past reservations, rate your ride, track your driver, cancel an existing reservation, and to schedule a new reservation. CTC-Go is available on iOS and Android. Search your app store for “CTC-Go” and download the application.<br><br>** Services do not apply to the plan’s maximum out-of-pocket limit.* | $0 |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **Transportation: Non-medical transportation**<br>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.<br>Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs.<br>This benefit does not limit your non-emergency medical transportation benefit. | $0 |
| | **Urgent care**<br>Urgent care is care given to treat:<br>• A non-emergency that requires immediate medical care, **or**<br>• A sudden medical illness, **or**<br>• An injury, **or**<br>• A condition that needs care right away.<br>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 can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).<br>Worldwide coverage.*<br>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.<br>* Services do not apply to the plan's maximum out-of-pocket limit. | $0 |

| | Services that our plan pays for | What you must pay |
|---|---|---|
| | **Vision care*** <br><br> We pay for the following services: <br><br> • Routine Eye Exam <br> • Contact lenses or eyeglasses (frames and lenses) <br><br> *Prior authorization (approval in advance) **IS** required for a routine eye exam and materials*. Use the *Vision Directory* or go to **blueshieldca.com/find-a-doctor** to locate a provider participating in the Vision Service Plan (VSP) (Blue Shield Vision Plan Administrator) network. <br><br> * Services do not apply to the plan's maximum out-of-pocket limit. <br><br> We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. <br><br> For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: <br> • People with a family history of glaucoma <br> • People with diabetes <br> • African-Americans who are age 50 and older <br> • Hispanic Americans who are 65 or older <br><br> We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. <br><br> 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. | You pay $0 for one exam per year. <br><br> You pay $0 for either contact lenses **OR** for one pair of eyeglasses (frames and lenses) priced up to $350 every year. If you choose contact lenses or eyeglasses (frames and lenses) priced above $350, you are responsible for the difference. |

| Services that our plan pays for | | What you must pay |
|---|---|---|
| | **"Welcome to Medicare" preventive visit**<br><br>We cover the one-time "Welcome to Medicare" preventive visit. The visit includes:<br>• A review of your health,<br>• Education and counseling about the preventive services you need (including screenings and shots), **and**<br>• Referrals for other care if you need it.<br><br>**Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. | $0 |

## Routine Dental Benefits Procedure Chart

Routine dental benefits are included for all Members in this plan

The following ***Routine Dental Benefits Procedure Chart*** shows specific dental procedures covered by the routine dental benefit and what you will pay for those procedures. The services listed are covered benefits when provided by an in-network, licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice.

**Important**: Please note that procedures not listed are not covered.

**Important**: Some dental services are not covered under any conditions (also known as Exclusions) and some dental services are only covered under specific conditions (also known as Limitations).
Please refer to the "General limitations" and "General exclusions" listed after this benefits chart for more information.

Benefits will be provided for specific dental procedures necessary to treat specified emergent, painful or infective acute dental conditions, or when provided in a manner consistent with professionally recognized standard of care. The Plan reserves the right to administratively review, by a Plan dental director, the submitted documentation of the

above conditions for coverage determination.

Conditions characterized by acute pain or infection include the following:

- Acute pain requiring immediate root canal;
- Acute pain requiring tooth extraction or removal and/or incision and drainage;
- Acute periodontal abscess requiring emergency periodontal procedures.

Emergent restorative conditions include the following:

- A tooth that is undergoing restoration that was begun as a (Basic Restorative) filling, but due to the extent of decay/fracture found during the course of its restoration, is now required to have a (Major Restorative) cast crown placed.

Services are listed with the American Dental Association (ADA) procedure code based on the current dental terminology. Federal law requires the use of the ADA code to report dental procedures. Procedure codes may be revised from time to time by the ADA. Therefore, the Plan may revise this code list as required by law. You can obtain an updated ADA code list by contacting the Dental Plan Administrator (DPA) customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30.

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| **Diagnostic Services** | | |
| D0150 | Comprehensive oral evaluation - new or established patient | $0 |
| D0171 | Re-evaluation, post-operative office visit | $0 |
| D0190 | Screening of a patient | $0 |
| D0191 | Assessment of a patient | $0 |
| D0251 | Extra-oral posterior dental radiographic image | $0 |
| D0415 | Collection of microorganisms for culture and sensitivity | $0 |
| D0425 | Caries susceptibility test | $0 |
| D0460 | Pulp vitality tests | $0 |
| D0470 | Diagnostic casts | $0 |
| D0472 | Accession of tissue, gross examination, preparation and transmission of written report | $0 |
| D0473 | Accession of tissue, gross and microscopic examination, preparation and transmission of written report | $0 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D0474 | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report | $0 |
| **Preventive Services** | | |
| D1110 | Prophylaxis – adult | $0 |
| D1206 | Topical application of fluoride varnish | $0 |
| D1208 | Topical application of fluoride - excluding varnish | $0 |
| D1353 | Sealant repair - per tooth | $10 |
| D1520 | Space maintainer - removable – unilateral – per quadrant | $70 |
| **Restorative Services** | | |
| D2140 | Amalgam - one surface, primary or permanent | $0 |
| D2510 | Inlay - metallic - one surface | $170 |
| D2520 | Inlay - metallic - two surfaces | $180 |
| D2530 | Inlay - metallic - three or more surfaces | $190 |
| D2542 | Onlay - metallic - two surfaces | $185 |
| D2543 | Onlay - metallic - three surfaces | $195 |
| D2544 | Onlay - metallic - four or more surfaces | $215 |
| D2610 | Inlay - porcelain/ceramic - one surface | $295 |
| D2620 | Inlay - porcelain/ceramic - two surfaces | $330 |
| D2630 | Inlay - porcelain/ceramic - three or more surfaces | $350 |
| D2642 | Onlay - porcelain/ceramic - two surfaces | $325 |
| D2643 | Onlay - porcelain/ceramic - three surfaces | $360 |
| D2644 | Onlay - porcelain/ceramic - four or more surfaces | $380 |
| D2650 | Inlay - composite/resin - one surface | $195 |
| D2651 | Inlay - composite/resin - two surfaces | $220 |
| D2652 | Inlay - composite/resin - three or more surfaces | $255 |
| D2662 | Onlay - composite/resin - two surfaces | $250 |
| D2663 | Onlay - composite/resin - three surfaces | $275 |
| D2664 | Onlay - composite/resin - four or more surfaces | $320 |
| D2720 | Crown - resin with high noble metal | $320 |
| D2722 | Crown - resin with noble metal | $260 |
| D2750 | Crown - porcelain fused to high noble metal | $380 |
| D2752 | Crown - porcelain fused to noble metal | $320 |
| D2753 | Crown - porcelain fused to titanium and titanium alloys | $380 |
| D2780 | Crown, 3/4 cast high noble metal | $380 |
| D2782 | Crown, 3/4 cast noble metal | $320 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D2790 | Crown - full cast high noble metal | $380 |
| D2792 | Crown - full cast noble metal | $320 |
| D2794 | Crown - titanium | $380 |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp | $50 |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth - anterior | $75 |
| D2940 | Protective restoration | $0 |
| D2981 | Inlay repair necessitated by restorative material failure | $25 |
| D2982 | Onlay repair necessitated by restorative material failure | $25 |
| D2983 | Veneer repair necessitated by restorative material failure | $25 |
| **Endodontic Services** | | |
| D3110 | Pulp cap - direct (excluding final restoration) | $0 |
| D3331 | Treatment of root canal obstruction, non-surgical access | $0 |
| D3333 | Internal tooth repair of preformation defects | $50 |
| D3346 | Retreatment of previous root canal therapy - anterior | $0 |
| D3348 | Retreatment of previous root canal therapy - molar | $0 |
| D3353 | Apexification/recalcification - final visit (includes completed root | $80 |
| D3450 | Root amputation - per root | $85 |
| D3920 | Hemisection (including any root removal), not including root canal therapy | $150 |
| **Periodontic Services** | | |
| D4212 | Gingivectomy or gingivoplasty to allow access for restoration procedure, per tooth | $85 |
| D4240 | Gingival flap procedure, including root planning - four or more contiguous teeth or tooth bounded spaces per quadrant | $150 |
| D4241 | Gingival flap procedure - including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant | $225 |
| D4245 | Apically positioned flap | $75 |
| D4260 | Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant | $0 |
| D4263 | Bone replacement graft - retained natural tooth - first site in quadrant | $225 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D4264 | Bone replacement graft - retained natural tooth - each additional site in quadrant | $80 |
| D4270 | Pedicle soft tissue graft procedure | $225 |
| D4274 | Mesial/distal wedge procedure single tooth (when not performed in conjunction with surgical procedures in the same area | $225 |
| D4277 | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth | $295 |
| D4278 | Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site | $295 |
| D4921 | Gingival irrigation - per quadrant | $0 |
| **Prosthodontic Services (Removable)** | | |
| D5110 | Complete denture - maxillary | $0 |
| D5221 | Immediate maxillary partial denture - resin base | $365 |
| D5222 | Immediate mandibular partial denture - resin base | $365 |
| D5223 | Immediate maxillary partial denture - cast metal framework with resin denture bases | $415 |
| D5224 | Immediate mandibular partial denture-cast metal framework with resin denture bases | $415 |
| D5225 | Maxillary partial denture - flexible base (including retentive/clasping materials, rests and teeth) | $180 |
| D5226 | Mandibular partial denture - flexible base (including retentive/clasping materials rests and teeth) | $180 |
| D5670 | Replace all teeth and acrylic on cast metal framework (maxillary) | $100 |
| D5671 | Replace all teeth and acrylic on cast metal framework (mandibular) | $100 |
| D5710 | Rebase complete maxillary denture | $100 |
| D5711 | Rebase complete mandibular denture | $100 |
| D5720 | Rebase maxillary partial denture | $100 |
| D5721 | Rebase mandibular partial denture | $110 |
| D5820 | Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary. Includes any necessary clasps and rests. | $380 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D5821 | Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular. Includes any necessary clasps and rests. | $320 |
| **Prosthodontic Services (Fixed)** | | |
| D6210 | Pontic - cast high noble metal | $380 |
| D6212 | Pontic - cast noble metal | $320 |
| D6240 | Pontic - porcelain fused to high noble metal | $320 |
| D6242 | Pontic - porcelain fused to noble metal | $320 |
| D6243 | Pontic – porcelain fused to titanium and titanium alloys | $260 |
| D6250 | Pontic - resin with high noble metal | $330 |
| D6252 | Pontic - resin with noble metal | $350 |
| D6600 | Retainer inlay - porcelain/ceramic, two surfaces | $280 |
| D6601 | Retainer inlay - porcelain/ceramic, three or more surfaces | $290 |
| D6602 | Retainer inlay - cast high noble metal, two surfaces | $180 |
| D6603 | Retainer inlay - cast high noble metal, three or more surfaces | $190 |
| D6604 | Retainer inlay - cast predominantly base metal, two surfaces | $210 |
| D6605 | Retainer inlay - cast predominantly base metal, three or more surfaces | $220 |
| D6606 | Retainer inlay - cast noble metal, two surfaces | $325 |
| D6607 | Retainer inlay - cast noble metal, three or more surfaces | $360 |
| D6608 | Retainer onlay - porcelain/ceramic, two surfaces | $285 |
| D6609 | Retainer onlay - porcelain/ceramic, three or more surfaces | $295 |
| D6610 | Retainer onlay - cast high noble metal, two surfaces | $185 |
| D6611 | Retainer onlay - cast high noble metal, three or more surfaces | $195 |
| D6612 | Retainer onlay - cast predominantly base metal, two surfaces | $205 |
| D6613 | Retainer onlay - cast predominantly base metal, three or more surfaces | $225 |
| D6614 | Retainer onlay - cast noble metal, two surfaces | $320 |
| D6615 | Retainer onlay - cast noble metal, three or more surfaces | $260 |
| D6720 | Retainer crown - resin with high noble metal | $380 |
| D6722 | Retainer crown - resin with noble metal | $320 |
| D6750 | Retainer crown - porcelain fused to high noble metal | $380 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D6752 | Retainer crown - porcelain fused to noble metal | $380 |
| D6753 | Retainer crown – porcelain fused to titanium and titanium alloys | $320 |
| D6780 | Retainer crown - 3/4 cast high noble metal | $380 |
| D6782 | Retainer crown- 3/4 cast noble metal | $380 |
| D6784 | Retainer crown ¾ - titanium and titanium alloys | $320 |
| D6790 | Retainer crown - full cast high noble metal | $45 |
| D6792 | Retainer crown - full cast noble metal | $320 |
| D6940 | Stress breaker | $45 |
| **Oral and Maxillofacial Surgery Services** | | |
| D7111 | Extraction, coronal remnants - primary tooth | $0 |
| D7140 | Extraction, erupted tooth or exposed root (elevation and/or forceps removal) | $0 |
| D7210 | Extraction, erupted tooth req removal of bone, sectioning of tooth and including elevation of mucoperiosteal flap | $0 |
| D7220 | Removal of impacted tooth - soft tissue | $0 |
| D7241 | Removal of impacted tooth - completely bony, with unusual surgical | $0 |
| D7251 | Coronectomy - intentional partial tooth removal | $130 |
| D7282 | Mobilization of erupted or malpositioned tooth to aid eruption | $90 |
| D7510 | Incision and drainage of abscess - intraoral soft tissue | $0 |
| **Orthodontic Services** | | |
| D8010 | Limited orthodontic treatment of the primary dentition | $1,150 |
| D8040 | Limited orthodontic treatment for adult dentition - adults | $1,350 |
| D8090 | Comprehensive orthodontic treatment of the adult dentition - adults | $2,100 |
| **Adjunctive General Services** | | |
| D9311 | Consultation with medical health care professional | $0 |
| D9450 | Case presentation detailed and extensive treatment planning | $0 |
| D9932 | Cleaning and inspection of removable complete denture, maxillary | $0 |
| D9933 | Cleaning and inspection of removable complete denture, mandibular | $0 |
| D9934 | Cleaning and inspection of removable partial denture, maxillary | $0 |

| ADA Code | ADA description of services covered for you | What you must pay |
|---|---|---|
| D9935 | Cleaning and inspection of removable partial denture, mandibular | $0 |
| D9943 | Occlusal adjustment | $10 |
| D9944 | Occlusal guard – hard appliance, full arch | $100 |
| D9945 | Occlusal guard – soft appliance, full arch | $100 |
| D9946 | Occlusal guard – hard appliance, partial arch | $100 |
| D9975 | External bleaching for home application, per arch includes materials and fabrication of custom trays - limited to one bleaching tray and gel for two weeks of self-treatment | $125 |
| D9986 | Missed appointment - without 24-hour notice - per 15 minutes of appointment time | $10 |
| D9987 | Canceled appointment - without 24-hour notice - per 15 minutes of appointment time. | $10 |

**NOTE:** Unless you require non-Medicare covered emergency dental services, the listed Member Cost-Sharing amounts only apply when you receive dental services from an in-network dentist (See “Non-Medicare covered emergency dental care”).

**NOTE:** Since Blue Shield contracts with Medicare each year, these routine dental benefits may not be available next year.

### Getting Routine Dental Care

#### Introduction

Blue Shield’s dental Plan is administered by a contracted Dental Plan Administrator (DPA), an entity that contracts with Blue Shield to administer the delivery of dental services through a network of contracted dentists. If you have any questions regarding the information in this dental section, need assistance, or have any problems, you may contact the DPA customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30.

#### Before Obtaining Routine Dental Services

You are responsible for assuring that the dentist you choose is an in-network dentist.

**NOTE**: An in-network dentist's status may change. It is your obligation to verify whether your dentist is currently an in-network dentist in case there have been any changes to the list of contracted dentists. A list of in-network dentists located in your area can be obtained by contacting the DPA customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays from October 1 to March 31 and weekdays from April 1 to September 30.

### Visiting Your Dentist

Shortly after enrollment you will receive a membership packet from the DPA that tells you the effective date of your benefits and the address and telephone number of your in-network dentist or primary care dentist (PCD). After the effective date in your membership packet, you may obtain covered dental care services. To make an appointment simply call your PCD's facility and identify yourself as a Blue Shield TotalDual Plan Member. Initial appointments should be scheduled within four weeks unless a specific time has been requested. Inquiries regarding availability of appointments and accessibility of dentists should be directed to the DPA customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30.

**NOTE:** Each Member must go to his or her assigned PCD to obtain covered services, except for services provided by a specialist preauthorized in writing by the DPA, or for non-Medicare covered emergency dental care services. Any other treatment is not covered under Blue Shield TotalDual Plan.

You must contact your PCD for all dental care needs including preventive services, routine dental problems, consultation with plan specialists, and emergency services (when possible). The PCD is responsible for providing general dental care services and coordinating or arranging for referral to other necessary plan specialists. The Plan must authorize such referrals.

This in-network only dental Plan does not pay benefits to out-of-network dentists. Services obtained from an out-of-network dentist will not be covered, except if there is a dental emergency. When you receive services from an out-of-network dentist, you will be responsible for paying the dentist directly for the entire amount billed by the dentist.

**NOTE**: Members who have not kept up with their routine dental appointments (once every 6 months) may find that they require services involving periodontal scaling and root planing before routine care such as regular cleanings can or will be provided.

### Member Copayments

Prior to beginning your treatment, your dentist will design a treatment plan to meet your individual needs. It is best to discuss your treatment plan and financial responsibilities with your dentist prior to beginning treatment.

Copayments are due and payable at time of service or inception of care.

If you need additional assistance in getting information about your treatment plan or if you have any questions about the Copayments you are charged for covered dental procedures, you may contact the DPA customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30.

**Choice of primary care dentist**

At the time of enrollment, you must select an in-network dentist to be your PCD. If you fail to select an in-network dentist or the in-network dentist selected becomes unavailable, the DPA will request the selection of another in-network dentist or assign you to an in-network dentist. You may change your assigned in-network dentist by contacting the DPA customer service department at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30.In order to ensure that your in-network dentist is notified and the DPA's eligibility lists are correct, changes to in-network dentists must be requested prior to the 21st of the month for the changes to be effective the first day of the following month.

**If your dentist no longer contracts with the Blue Shield TotalDual Plan DPA**

If your selected in-network dentist is unable to continue under contract with the DPA because he or she is unable to perform or has breached the contract, or if the DPA has canceled the contract, the DPA will notify you at least 30 days prior to the dentist's effective termination date so you may select another dentist.

If you are notified by the DPA of the need to select another dentist for this reason, fees for the duplication and transfer of X-rays or other records are waived. Also, the in-network dentist will complete (a) a partial or full denture for which final impressions have been taken, and (b) all work on every tooth upon which work has started (such as completion of root canals in progress and delivery of crowns when teeth have been prepared).

**Non-Medicare covered emergency dental care**

Non-Medicare covered emergency services means care provided by a dentist to treat a dental condition that manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Member to result in either: (i) placing the Member's dental health in serious jeopardy, or (ii) serious impairment to dental functions.

**In-area non-Medicare covered emergency dental care**

If you feel you need non-Medicare covered emergency dental care and you are in the Blue Shield TotalDual Plan Service Area, immediately call your assigned network dentist. The dental office personnel will advise you what to do.

### Out-of-area non-Medicare covered emergency dental care

If you are outside the Blue Shield TotalDual Plan Service Area and require non-Medicare covered emergency dental care, you may obtain treatment from any licensed dentist. The services you receive from the out-of-area dentist are covered up to $100 (minus any applicable Member Copayments) as long as transfer to a Network Provider is a risk to your health.

### Reimbursement for out-of-area non-Medicare covered emergency dental care

You will be reimbursed up to $100 (minus any applicable Member Copayments) for the cost of covered out-of-area non-Medicare covered emergency dental services. Whenever possible, you should ask your dentist to send the bill directly to Blue Shield at the address listed below.

To obtain reimbursement, submit your request for reimbursement, payment receipt, and description of services rendered in writing to:
Blue Shield of California
Claims Department
P.O. Box 1803
Alpharetta, GA 30023

There are time limits for filing claims. Generally, bills for services must be submitted to Blue Shield within one year of the date of service, unless there is a reason for filing later.

Our DPA will review the non-Medicare covered emergency dental service you received and notify you within 30 days from receipt of the claim if you qualify for reimbursement. Except for non-Medicare covered emergency dental services, you will be responsible for full payment of dental services you receive outside of California.

### Denial of a reimbursement claim for out-of-area non-Medicare covered emergency dental care

If your claim for reimbursement of out-of-area non-Medicare covered emergency dental care is partially or fully denied, the DPA will notify you of the decision, in writing. The notification will include the specific reason for the denial and will inform you that you may request a reconsideration of the denial.

To request reconsideration of the denial or partial denial, submit a written notice to Blue Shield TotalDual Plan within 60 calendar days from the date on the written denial notice.

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

**Obtaining a second opinion for dental care**
You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your in-network dentist. The DPA may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of benefits.

Second opinions will be rendered by a licensed dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, call the DPA customer service department at **866-247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., seven days a week (except holidays) from October 1 to March 31, and weekdays from April 1 to September 30 or write to the DPA.

Second opinions will be provided at another in-network dentist's facility, unless otherwise authorized by the DPA. The DPA will authorize a second opinion by an out-of-network provider if an appropriately qualified in-network dentist is not available. The DPA will only pay for a second opinion which the DPA approved or authorized. You will be sent a written notification should the DPA decide not to authorize a second opinion. If you disagree with this determination, you may file an appeal with Blue Shield TotalDual Plan. Refer to the *Grievance and Appeals* section for additional information.

**Coordination of benefits**

This Plan provides benefits without regard to coverage by any other group insurance policy or any other group health benefits program if the other policy or program covers services or expenses in addition to dental care. Otherwise, benefits provided under this Plan by specialists or out-of-network dentists are coordinated with such other group dental insurance policies or any group dental benefits programs. The determination of which policy or program is primary shall be governed by the rules stated in the contract.

If this Plan is secondary, it will pay the lesser of:
- The amount that it would have paid in the absence of any other dental benefit coverage, or;
- The Member’s total out-of-pocket cost payable under the primary dental benefit plan as long as the benefits are covered under this Plan.

A Member must provide to the DPA and the DPA may release to or obtain from any insurance company or other organization, any information about the Member that is needed to administer coordination of benefits. The DPA shall, in its sole discretion, determine whether any reimbursement to an insurance company or other organization is warranted under the coordination of benefits provisions described herein, and any such reimbursement paid shall be deemed to be benefits under this contract. The DPA will

have the right to recover from a dentist, Member, insurance company or other organization, as the DPA chooses, the amount of any benefit paid by the DPA which exceeds its obligations under the coordination of benefits provisions described herein.

**Grievance and appeals process**

Our commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by in-network dentists to the courtesy extended you by our telephone representatives. If you have any question or complaint regarding eligibility, the denial of dental services or claims, the policies, procedures or operations of the DPA or the quality of dental services performed by an in-network dentist, you have the right to file a grievance or appeal with Blue Shield TotalDual Plan. Please go to *Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)* for more information on how to file a grievance or appeal. If you have any questions, call the DPA at **(866) 247-2486 [TTY: 711]**, 8 a.m. to 8 p.m., 7 days a week (except holidays) from October 1 to March 31 and weekdays from April 1 to September 30. You may also contact Blue Shield TotalDual Plan Customer Care (phone numbers are printed on the back cover of this document).

**General limitations for the routine dental HMO Plan**

1. Oral examinations are limited to one (1) every three (3) calendar years, per provider or location (D0150).

2. Prophylaxis or scaling is limited to two (2) per calendar year (D1110).

3. Topical fluoride application (excluding varnish) is limited to two (2) per calendar year (D1208).

4. Crown – porcelain fused to noble metal are limited to 2 per calendar year per patient (D2750).

5. Denture – immediate maxillary partial denture – cast metal framework with resin denture bases 1 per 5 calendar years. (D5223).

6. Periodontics - gingival flap procedure - including root planing planning -one to three contiguous teeth or tooth bounded spaces per quadrant (D4241).

7. Partial denture is limited to one (1) in any twelve (12) consecutive months (D5820 and D5821).

8. The cost to a Member receiving orthodontic treatment whose coverage is cancelled or terminated for any reason will be based on the in-network Orthodontist's usual fee for the

treatment plan. The in-network Orthodontist will prorate the amount for the number of months remaining to complete treatment. The Member makes payment directly to the in-network Orthodontist as arranged.

**General exclusions for the routine dental HMO Plan**

1. Any procedure that is not specifically listed in the *Routine Dental Benefits Procedure Chart*.
2. Any procedure that in the professional opinion of the in-network dentist:
   a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
   b. is inconsistent with generally accepted standards for dentistry.
3. Services solely for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Lost or stolen appliances including, but not limited to, full or partial dentures, space maintainers, crowns and fixed partial dentures (bridges).
5. Procedures, appliances or restoration if the purpose is to change vertical dimension, or to diagnose or treat abnormal conditions of the temporomandibular joint (TMJ).
6. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
7. Implant-supported dental appliances and attachments, implant placement, maintenance, removal and all other services associated with a dental implant.
8. Consultations for non-covered benefits.
9. Dental services received from any dental facility other than the assigned in-network dentist, a preauthorized dental specialist, or an in-network Orthodontist except for emergency dental care services as described in the Evidence of Coverage.
10. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
11. Prescription drugs.
12. Dental expenses incurred in connection with any dental or orthodontic procedure started before the Member's eligibility with the Blue Shield TotalDual Plan. Examples include: teeth prepared for crowns, root canals in progress, full or partial dentures for which an impression has been taken and orthodontics.

13. Changes in orthodontic treatment necessitated by accident of any kind.

14. Myofunctional and parafunctional appliances and/ or therapies.

15. Composite or ceramic brackets, lingual adaptation of orthodontic bands and other specialized or cosmetic alternatives to standard fixed and removable orthodontic appliances.

16. Extraction of teeth, when teeth are asymptomatic/ non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars and orthodontic extractions.

17. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.

18. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed in the *Routine Dental Benefits Procedure Chart*. If a member declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered benefits.

19. Treatment or appliances that are provided by a dentist whose practice specializes in prosthodontic services.

20. Orthodontic treatment must be provided by a licensed dentist. Self-administered orthodontics are not covered.

21. The removal of fixed orthodontic appliances for reasons other than completion of treatment is not a covered benefit.

## E. Benefits covered outside of our plan

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

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

**For CCT transition coordination services**

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

**For services not related to your CCT transition**

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

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

**No change in drug coverage benefit**

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

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

## E2. Medi-Cal Dental Program

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

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- Root canal therapy
- 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, 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, 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 have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The

plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

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

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

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

**For services covered by Medicare Part A or 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 our plan's Medicare Part D benefit**

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

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

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

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medi-Cal do not for them either.

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

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

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

- Services considered not “reasonable and medically necessary,” according Medicare and Medi-Cal standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- 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

## 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** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook.*

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.

### Rules for our plan's outpatient drug coverage

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

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists, State Medi-Cal (Medicaid) Exclusion List and State Sanctioned.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on our 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.
    - Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

5. Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help you identify medical references to support the requested use of the prescribed drug. 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.
   - 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

### A1. Filling your prescription at a network pharmacy

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

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

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills 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.

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

If you don't have your plan ID card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, state and federal law permit the pharmacy to issue no less than a 72-hour supply of your needed prescription in an emergency. Contact Customer Care right away.** We will do everything we can to help.

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

### A3. What to do if you change your network pharmacy

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

If you need help changing your network pharmacy, contact Customer Care or your care coordinator.

### A4. What to do if your pharmacy leaves the network

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

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

### A5. Using a specialized pharmacy

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

Pharmacies that supply drugs for home infusion therapy.

Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing home.

- Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.

- If your long-term care facility's pharmacy is not in our network or you have difficulty accessing your drug benefits in a long-term care facility, 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 dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

### A6. Using mail service to get your drugs

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

Our plan's mail service allows you to order up to a 100-day supply for Tier 1: Preferred Generic Drugs and a 90-day supply for Tier 2: Generic Drugs, Tier 3: Preferred Brand Drugs and Tier 4: Non-Preferred Drugs. A 90-day and 100-day supply has the same copay as a one-month supply.

### Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please call Customer Care at the number on the back cover of this booklet. If you use a mail service pharmacy not in the plan's network, your prescription will not be covered.

Usually, a mail service prescription arrives within 14 days.

However, sometimes your mail service prescription may be delayed. If you receive notification that there may be a delay in the shipment of your prescription, at no fault of your own, by the mail service pharmacy, please contact Customer Care at the number on the back cover of this booklet. A Blue Shield 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.

### Mail service processes

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 prescriptions.

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

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

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

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

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

3. **Refills on mail service prescriptions**

   For refills, contact your pharmacy **14** days before your current prescription will run out to make sure your next order is shipped to you in time.

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

## 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. 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 our plan's network mail service to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail service pharmacy.

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy.

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

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at an eligible network retail or mail service pharmacy (these drugs include orphan drugs, high cost and unique drugs or other specialty pharmaceuticals).
- Some vaccines administered in your physician's office that are not covered under Medicare Part B and cannot reasonably be obtained at a network pharmacy may be covered under our out-of-network access.
- Prescriptions filled at out-of-network pharmacies are limited to a 30-day supply of covered medications.

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

### A9. Paying you back for a prescription

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

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

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

## B. Our plan's Drug List

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

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

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

## B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare.

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

*Our Drug List includes brand name drugs, generic drugs, and biosimilars.*

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generic drugs and biosimilars work just as well as brand-name drugs and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

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

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

Check the most recent Drug List we provided electronically.

Visit our plan’s website at **blueshieldca.com/medformulary2023**. The Drug List on our website is always the most current one.

Call Customer Care to find out if a drug is on our Drug List or to ask for a copy of the list.

Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information

### B3. Drugs not on our Drug List

We don't cover all prescription drugs. Some drugs are not on our Drug List because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List. If a drug was prescribed that is not on our Drug List, your prescription drug needs will always be evaluated under our plan's coverage policies, as well as Medicare coverage rules.

Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Member Handbook* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D) cannot pay for a drug that Medicare Part A or Part B already covers. Our plan covers drugs covered under Medicare Part A or Part B for free, but these drugs aren't considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn't approved to treat the condition. This is called "off-label use." Our plan usually doesn't cover drugs prescribed for off-label use.

Also, by law, Medicare or Medi-Cal cannot cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for 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 made by a company that says you must have tests or services done only by them

### B4. Drug List cost sharing tiers

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

- Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs.
- Cost-Sharing Tier 2: Generic Drugs
  Includes generic drugs.
- Cost-Sharing Tier 3: Preferred Brand Drugs
  Includes preferred brand name and some generic drugs.
- Cost-Sharing Tier 4: Non-Preferred Drugs
  Includes non-preferred brand name and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high cost brand name and generic drugs which may require special handling and/or close monitoring

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

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

## C. Limits on some drugs

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

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

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

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

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

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug won't work for you, then we cover the brand name drug.

**2. Getting plan approval in advance**

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

**3. Trying a different drug first**

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

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

**4. Quantity limits**

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

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Customer Care or check our website at **blueshieldca.com/medformulary2023**. If you disagree with our coverage or exception request decision, you may request an appeal. For more information about this, refer to section E in Chapter 9.

## D. Reasons your drug might not be covered

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

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage for the drug. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

## D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

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

1. The drug you've been taking:
    - is no longer on our Drug List **or**
    - was never on our Drug List **or**
    - is now limited in some way
2. You must be in one of these situations:
    - You were in our plan last year.
        - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

    You are new to our plan.

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

- You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
    - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
    - To ask for a temporary supply of a drug, call Customer Care.

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

- Change to another drug.

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

  **OR**

- Ask for an exception.

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

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

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

If you need help asking for an exception, contact Customer Care or your care coordinator. If you disagree with our coverage or exception request decision, you may request an appeal (For more information about this, refer to section E in Chapter 9.).

## E. Coverage changes for your drugs

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

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

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

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

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

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

- Check our current Drug List online at blueshieldca.com/medformulary2023 **or**
- Call Customer Care at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List 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 our 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 stays 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 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 send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your Member 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 take it off our Drug List. If you are taking the drug, we tell you. Your prescriber will also know about this change and can work with you to find another drug for your condition.

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

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

When these changes happen, we:

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

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

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

**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 do not remove or change coverage of that drug **during the rest of the year**.

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

## F. Drug coverage in special cases

### F1. In a hospital or a skilled nursing facility for a stay that our plan covers

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

To learn more about drug coverage and what you pay, refer to **Chapter 6** of your *Member Handbook.*

### F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing home, has their own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

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

### F3. In a Medicare-certified hospice program

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

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

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

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

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

## G. Programs on drug safety and managing drugs

### G1. Programs to help you use drugs safely

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

- May not be needed because you take another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

### G2. Programs to help you manage your drugs

You may take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely. In such cases, 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 of your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take and why you take them.
- 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.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

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

If you have questions about these programs, contact Customer Care or your care coordinator.

### G3. Drug management program for safe use of opioid medications

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

If you use opioid medications that you get from several 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 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 certain pharmacies and/or from a certain doctor
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains 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 medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you a written decision. If we continue to deny any part of your appeal related to limitations to your access to these

medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9** of your *Member Handbook*.)

The DMP may not apply to you if you:

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

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

## Introduction

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

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

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

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

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

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

- Our *List of Covered Drugs*.
    - We call this the “Drug List.” It tells you:
        - Which drugs we pay for
        - Which of the five tiers each drug is in
        - If there are any limits on the drugs
    - If you need a copy of our Drug List, call Customer Care. You can also find the most current copy of our Drug List on our website at blueshieldca.com/medformulary2023.

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

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

## Table of Contents

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

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

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- 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 *Part D Explanation of Benefits*. If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D Explanation of Benefits ("Part D EOB"). We call it the Part D EOB for short. The Part D 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 Part D 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 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 do not count towards your total out-of-pocket costs.
- Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information. You can also call the Medi-Cal customer service center at 800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.
- To find out which drugs our plan covers, refer to our Drug List.

## B. How to keep track of your drug costs

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

1. **Use your plan ID card.**

   Show your Blue Shield TotalDual ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. **Make sure we have the information we need.**

   Give us copies of receipts for drugs that you 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

For more information about asking us to pay you back for our share of the cost of a drug, refer to **Chapter 7** *o*f your Member Handbook.

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

   Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, 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, our 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 a Part D EOB in the mail, make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, call Customer Care. Keep these Part D 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 our 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 |
|---|---|
| During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.<br><br>You begin in this stage when you fill your first prescription of the year. | During this stage, we pay all of the costs of your drugs through December 31, 2023.<br><br>You begin this stage when you have paid a certain amount of out-of-pocket costs. |

**Important Message About What You Pay for Insulin** - You won’t pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what cost-sharing tier it’s on.

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

- Cost-Sharing Tier 1: Preferred Generic Drugs (lowest cost-sharing tier)
  Includes preferred generic drugs.
- Cost-Sharing Tier 2: Generic Drugs
  Includes generic drugs.
- Cost-Sharing Tier 3: Preferred Brand Drugs
  Includes preferred brand name and some generic drugs.
- Cost-Sharing Tier 4: Non-Preferred Drugs

  Includes non-preferred brand name and some generic drugs.
- Cost-Sharing Tier 5: Specialty Tier Drugs (highest cost-sharing tier)
  Includes very high-cost brand name and generic drugs which may require special handling and/or close monitoring.

### D1. Your pharmacy choices

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

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

In limited cases, we cover prescriptions filled at out-of-network pharmacies. Refer to **Chapter 5** *of your Member Handbook* to find out when we do that.

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to 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 drugs on Tier 1 and a 90-day supply for drugs on Tiers 2, 3, and 4. 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** *of your Member Handbook* or our plan’s *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 pay the lower price.

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**<br><br>A one-month or up to a 30-day supply | **Our plan's mail service**<br><br>A one-month or up to a 30-day supply | **A network long-term care pharmacy**<br><br>Up to a 31-day supply | **An out-of-network pharmacy**<br><br>Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details. |
|---|---|---|---|---|
| **Cost-sharing Tier 1**<br><br>(Preferred Generic Drugs) | $0 | | | |
| **Cost-sharing Tier 2**<br><br>(Generic Drugs) | Your co-pay depends on the level of Extra Help you receive:<br><br>$0, 1.45, or $4.15 | | | |

| | **A network pharmacy**<br><br>A one-month or up to a 30-day supply | **Our plan's mail service**<br><br>A one-month or up to a 30-day supply | **A network long-term care pharmacy**<br><br>Up to a 31-day supply | **An out-of-network pharmacy**<br><br>Up to a 30-day supply. Coverage is limited to certain cases. Refer to **Chapter 5** of your *Member Handbook* for details. |
|---|---|---|---|---|
| **Cost-sharing Tier 3**<br>(Preferred Brand Drugs) | Your co-pay depends on the level of Extra Help you receive:<br>$0, $4.30, $10.35 | | | |
| **Cost-sharing Tier 4**<br>(Non-Preferred Drugs) | Your co-pay depends on the level of Extra Help you receive:<br>$0, $4.30, $10.35 | | | |
| **Cost-sharing Tier 5**<br>(Specialty Tier Drugs) | Your co-pay depends on the level of Extra Help you receive:<br>$0, $4.30, $10.35 | | | |

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 $7,400. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your Explanation of Benefits (EOB) helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the $7,400 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 $7,400 for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, our plan pays all of the costs for your Medicare drugs.

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

In some cases, 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 do not 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 is based on the number of days of the drug that you get. We 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 is less than $.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 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 to 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. The AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps eligible individuals living with HIV/AIDS access 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. If you are not enrolled in ADAP

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

### G3. If you are enrolled in ADAP

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

## H. Vaccinations

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Care for more information.

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 Customer Care if you plan to get a vaccination.

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

### H2. What you pay for a vaccination covered by Medicare Part D

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** *of your Member Handbook.*
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our 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 and your shot at a network pharmacy.
   - You pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay a copay to the doctor for the vaccine.
   - Our plan pays 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 at a pharmacy, and you take it to your doctor's office to get the shot.

- You pay a copay for the vaccine.
- Our plan pays for the cost of giving you the shot.

# Chapter 7: Asking us to pay our share of a bill you got for covered services or drugs

## Introduction

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

## Table of Contents

## A. Asking us to pay for your services or drugs

Our network providers must bill the health plan for your covered services and drugs after you get them. A network provider works with the health plan. **If you get a bill for** the full cost of **health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cos, it is your right to be paid back.
- If we do not cover the services or drugs, we will tell you.

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

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 (see C*hapter 3, section D4, page 52).***

   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 don't owe. Send us the bill and proof of any payment you made.
     - If the provider should be paid, we will pay the provider directly.
     - If you already paid 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.
   - Refer to **Chapter 5** of your Member Handbook to learn more about out-of-network pharmacies.

2. **When a network provider sends you a bill**

Network providers must always bill us. Show your plan ID card when you get any services or prescriptions. Improper or inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. **Call Customer Care if you get any bills. Do not pay the bill.**

- As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not 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 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 our plan.

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

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

- In only a few cases, we 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.
- Refer to **Chapter 5** of your Member Handbook to learn more about out-of-network pharmacies.

**4. When you pay the full prescription cost because you don't have your plan ID card with you**

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- 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 prescription cost for a drug that's not covered**

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug.

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

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Member Handbook*.

## B. Sending us a request for payment

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

To make sure you give us all the information we need to make a decision, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website (**blueshieldca.com**), or you can call *Customer Care and ask for the form.*

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

**Medical claims:**
Blue Shield TotalDual Plan
Medicare Customer Care
P.O. Box 927, Woodland Hills, CA 91365-9856

**Prescription drug claims:**
Blue Shield of California
P.O. Box 52066
Phoenix, AZ 85072-20

**You must submit your claim to us within one year** of the date you got the service, item, or drug.

## C. Coverage decisions

**When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.** We also decide the amount of money, if any, you must pay.

- We let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we pay our share of the cost for it. If you already paid for the service or drug, we will mail you a check for our share of the cost. If you haven't paid, we pay the provider directly.

**Chapter 3** *of your Member Handbook* explains the rules for getting your services covered. **Chapter 5** of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9.

## D. Appeals

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

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

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

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

# Chapter 8: Your rights and responsibilities

## Introduction

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

## Table of Contents

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

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Customer Care. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, audio or alternate formats at no cost if you need it. 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, Ukranian, Vietnamese. To obtain materials in one of these alternative formats, please call or write to Blue Shield of California Civil Rights Coordinator, P.O. Box 629007, El Dorado Hills, CA 95762-9007, (844) 696-6070 (TTY: 711) or email: BlueShieldCivilRightsCoordinator@blueshieldca.com.
    - 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 TotalDual Plan Customer Care.
    - Blue Shield TotalDual 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 TotalDual Plan.

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

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

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

You have rights as a member of our plan.

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

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

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

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

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

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

Members who may consent to receive sensitive services are not required to obtain any other member's authorization to receive sensitive services or to submit a claim for sensitive services. Blue Shield TotalDual Plan will direct communications regarding sensitive services to a member's alternate designated mailing address, email address, or telephone number or, in the absence of a designation, in the name of the member at the address or telephone number on file. Blue Shield TotalDual Plan will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Blue Shield TotalDual Plan will accommodate requests for confidential communication in the form and format requested, if it is readily producible in the requested form and format, or at alternative locations. A member's request for confidential communications related to sensitive services will be valid until the member revokes the request or submits a new request for confidential communications.

1. Go to **blueshieldca.com** and click the Privacy link at the bottom of the homepage and print a copy.
2. Call the Customer Care phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield of California Privacy Office toll-free at (888) 266-8080, 8 a.m. to 3p.m., Monday through Friday. TTY users call 711.
4. Email us at: privacy@blueshieldca.com.

### C1. How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.
- We must provide your Medi-Cal PHI as we:
    - Help manage the healthcare treatment you receive
    - Run our organization
    - Pay for your health services
    - Administer your health plan
    - Help with public health and safety issues
    - Do research
    - Comply with the law
    - Respond to organ and tissue donation requests and work with a medical examiner or funeral director
    - Address workers' compensation, law enforcement, and other government requests
    - Respond to lawsuits and legal action

### C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.

- You have the right to know if and how we shared your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Customer Care.

## D. Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at (800) 452-4413 (TY: 711). 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, Ukranian, Vietnamese. We can also give you information in large print, braille or audio. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

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

- How to choose or change plans
- Our plan, including:
    - financial information
    - how plan members have rated us
    - the number of appeals made by members
    - how to leave our plan
- Our network providers and our network pharmacies, including:
    - how to choose or change primary care physicians
    - 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 (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
    - limits to your coverage and drugs

  - rules you must follow to get covered services and drugs

- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got

## E. Inability of network providers to bill you directly

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

## F. Your right to leave our plan

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

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

## G. Your right to make decisions about your health care

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

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

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

- **Know your choices.** You have the right to be told about different treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** *of your Member Handbook* tells how to ask us for a coverage decision.

## G2. Your right to say what you want to happen

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

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

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

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

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

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Blue Shield TotalDual Plan will tell you about changes to the state law no later than 90 days after the change.

Having an advance directive is **your** choice. Call Customer Care for more information.

### G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with Livanta (California's Quality Improvement Organization) at (877) 588-1123 (TTY: (855) 887-6668 or write to: BFCC-QIO Program 10820 Guilford Rd, Ste. 202, Annapolis Junction, MD 20701.

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

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

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

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

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

- Customer Care at 1-800-452-4413 (TTY: 711).
- The Health Insurance Counseling and Advocacy Program (HICAP) program at (800) 434-0222 (TTY: 711). For more details about HICAP, refer to Chapter 2, Section E.
- The Ombuds Program at 1-888-452-8609. For more details about this program, refer to **Chapter 2** *of your Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

## I. Your responsibilities as a plan member

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

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** *of your Member Handbook.* Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** *of your Member Handbook.*

- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Customer Care if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment**.**
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and with other providers.
- **Tell us about any services you receive outside of our plan.**
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - Medicare Part A and Medicare Part B premiums. For most 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 that our plan covers, you must pay your share of the cost when you get the service or drug.

**Tell us if you move.** If you plan to move, tell us right away. Call Customer Care.

- **If you move outside of our service area you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells you about our service area.

  - We can help you find out if you're moving outside our service area. We can tell you if we have a plan in your new area.
  - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- Call 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 said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.
- You have a problem or complaint with your long-term services and supports, which include Community-Based Adult Services (CBAS) and Nursing Facility (NF) services.

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Ombuds Program at 1-888-452-8609 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** *of your Member Handbook*.

## Table of Contents

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

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

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

### A1. About the legal terms

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

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” instead of “Independent Review Entity”

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

## B. Where to get help

### B1. For more information and help

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

#### *Help from the Health Insurance Counseling and Advocacy Program*

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

#### Help from the Health Consumer Alliance

You can call the Health Consumer Alliance and speak with an advocate about your health coverage questions. They offer free legal help. The Health Consumer Alliance is not connected with us or with any insurance company or health plan. Their phone number is 1-888-804-3536 and their website is www.healthconsumer.org.

#### Help and information from Medicare

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

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

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

**Help and information from Medi-Cal**

| Medi-Cal (Medicaid) Agencies by County (California) | | |
|---|---|---|
| **Your County** | **Agency Name** | **Call** |
| **Los Angeles County** | Department of Public Social Services | 1-866-613-3777 |
| **San Diego County** | Department of Health & Human Services Agency | 1-866-262-9881 |
| **WEBSITE:** | https://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx | |

**Help from the California Department of Health Care Services**

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

**Help from the California Department of Managed Health Care**

Contact the California Department of Managed Health Care for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.

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 1-800-452-4413 and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions

for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

## C. Understanding Medicare and Medi-Cal complaints and appeals in our plan

You have Medicare and Medi-Cal. Information in this chapter applies to **all** of your Medicare and Medi-Cal benefits. This is sometimes called an "integrated process" because it combines, or integrates, Medicare and Medi-Cal processes.

Sometimes Medicare and Medi-Cal processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for a Medi-Cal benefit. **Section F4** explains these situations.

## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.

<table>
<tr><td colspan="2">Is your problem or concern about your benefits or coverage?<br><br>This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.</td></tr>
<tr><td>Yes.<br>My problem is about benefits or coverage.<br><br>Refer to Section E, "Coverage decisions and appeals."</td><td>No.<br>My problem is not about benefits or coverage.<br><br>Refer to Section K, "How to make a complaint."</td></tr>
</table>

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

## E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

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

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

## E2. Appeals

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

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

In most cases, you must start your appeal at Level 1. If 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.dmhc.ca.gov. Refer to page 185 for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter Section F2, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. An Independent Review Organization that is not connected to us conducts the Level 2 Appeal.

- In some situations, your case is **automatically sent** to the Independent Review Organization for a Level 2 Appeal. If this happens, we tell you.
- In other situations, you **need to ask** for a Level 2 Appeal.
- Refer to **Section F4** for more information about Level 2 Appeals.

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

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Customer Care** at the numbers at the bottom of the page.
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
    - Ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.

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

Call Customer Care at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

### E4. Which section of this chapter can help you

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

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

If you're not sure which section to use, call Customer Care at the numbers at the bottom of the page. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

## F. Medical care

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

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Member Handbook.* We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items as well as Medicare Part B prescription drugs which are usually drugs administered by your doctor or health care professional. Different rules may apply to a Part B prescription drug. When they do, we explain how rules for Part B prescription drugs differ from rules for medical services and items.

### F1. Using this section

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

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

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

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

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

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

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

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

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

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

6. You are experiencing delays in care or you cannot find a doctor.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H** or **Section I** to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: (800) 452-4413 TTY: 711.
- Faxing: (877) 251-6671.

- Writing: BlueShield TotalDual Plan P.O. Box 927, Woodland Hills, CA 91365-9856.

**Standard coverage decision**

Blue Shield TotalDual Plan will decide routine pre=-approvals within 5 working days of when Blue Shield TotalDual Plan gets the information needed to make a decision, and no later than 14 calendar days after Blue Shield TotalDual Plan receives the request. When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer about a**:**

- Medical service or item within 5 business days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can’t take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**.

**Fast coverage decision**

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

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

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

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

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

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

If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

- We automatically give you a fast coverage decision if your doctor asks for it.
- How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

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

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

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

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

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

### F3. Making a Level 1 Appeal

**To start an appeal,** you, your doctor, or your representative must contact us. Call us at 1-800-452-4413 (TTY: 711).

**Ask for a standard appeal or a fast appeal** in writing or by calling us at 1-800-452-4413 (TTY: 711).

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal.
You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.
- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2**.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

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

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

**We consider your appeal and give you our answer.**

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

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process.

**If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

*If we say No to part or all of your request**, you have additional appeal rights:***

If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

## F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

**When your problem is about a service or item Medicare usually covers**

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" is the **"Independent Review Entity,"** sometimes called the **"IRE."**

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.

- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

**If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.**

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

**If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **If the Independent Review Organization says Yes to part or all of a request for a medical item or service,** we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours** or
  - Provide the service within **14 calendar days** after we get the Independent Review Organization's decision for **standard requests** or
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- If the Independent Review Organization says **Yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:

- **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests** or
- **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests.**

- If the Independent Review Organization says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If your case meets the requirements, you choose whether you want to take your appeal further.

There are three additional levels in the appeals process after Level 2, for a total of five levels.

If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.

An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

**When your problem is about a service or item Medi-Cal usually covers**

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

**(1) Independent Medical Review**

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by 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 216 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. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.

- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.

- Mail or fax your forms and any attachments to:

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

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 194 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.

The Fair Hearing office gives you their decision in writing and explain the reasons.

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

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

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

The letter you get from the Fair Hearing office describes the next appeal option.

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

### F5. Payment problems

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

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay your back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send 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 won't pay for the service or item and explaining why.

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

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

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and **Medi-Cal** usually covers the service or item, you can file a Level 2 Appeal yourself. We do not automatically file a level 2 appeal for you. Refer to **Section F4** for more information.

## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Part D drug appeals.** We'll say "drug" in the rest of this section Instead of saying "Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

## G1. Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

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

> An initial coverage decision about your Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

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

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

## G2. Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List**

- If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies to drugs in Tier 4: Non-Preferred Drugs.
- You can't get an exception to the required copay amount for the drug.

2. **Removing a restriction for a covered drug**

   - Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
   - Extra rules and restrictions for certain drugs include:
     - Being required to use the generic version of a drug instead of the brand name drug.
     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization."
     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
     - If we agree to an exception for you and set aside a restriction, you can ask for an exception to the copay amount you're required to pay.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less your required copay amount is.

> Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

- Our Drug List often includes more than one drug for treating a specific condition. These are called "alternative" drugs.
- If an alternative drug for your medical condition is in a lower cost-sharing tier than the drug you take, you can ask us to cover it at the cost-sharing amount for the alternative drug. This would lower your copay amount for the drug.

If the drug you take is a biological product, you can ask us to cover it at the cost-sharing amount for the lowest tier for biological product alternatives for your condition.

If the drug you take is a brand name drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for brand name alternatives for your condition.

If the drug you take is a generic drug, you can ask us to cover it at the cost-sharing amount for the lowest tier for either brand or generic alternatives for your condition.

- You can't ask us to change the cost-sharing tier for any drug in Tier 5: Specialty Tier Drugs.
- If we approve your tiering exception request and there is more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

## G3. Important things to know about asking for an exception

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

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

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

**We can say Yes or No to your request.**

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

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

## G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-800-452-4413 (TTY: 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information about the claim.

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

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

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

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

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

You can get a fast coverage decision if:

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

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

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.

- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.

We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.

You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

**Deadlines for a fast coverage decision**

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

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

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

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

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

## G5. Making a Level 1 Appeal

> An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard** or **fast appeal** by calling (800) 452-4413 (TTY: 711) 8a.m. to 8 p.m., seven days a week, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information regarding your claim.
- 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 the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

**If your health requires it, ask for a fast appeal.**

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

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

**Deadlines for a fast appeal at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**Deadlines for a standard appeal at Level 1**

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.

If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.

If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

### G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" is the **"Independent Review Entity,"** sometimes called the **"IRE."**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your "case file." **You have the right to a free copy of your case file**.

- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the Independent Review Organization.

**Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization's decision.

**Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn't get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.

If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal."

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook.*

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

### H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called **"An Important Message from Medicare about Your Rights."** Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Customer Care at the numbers at the bottom of the page. You can also call 1-800-

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

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
  - Be a part of any decisions about the length of your hospital stay.
  - Know where to report any concerns you have about the quality of your hospital care.
  - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Customer Care at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the Quality Improvement Organization is Livanta. Call them at (877) 588-1123 (TTY: (855) 887-6668). Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 193 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

**Ask for help if you need it**. If you have questions or need help at any time:

- Call Customer Care at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

> The legal term for **“fast review”** is **“immediate review”** or **“expedited review.”**

**What happens during fast review**

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you will get another notice that explains why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Customer Care at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at (877) 588-1123 (TTY: (855) 887-6668).

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page 187 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Customer Care at the numbers at the bottom of the page and ask us for a “fast review” of your hospital discharge date.

> The legal term for “fast review” or “fast appeal” is **“expedited appeal.”**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We 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 appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don’t need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section F4 on page 193 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.

## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- Home health care services
- Skilled nursing care in a skilled nursing facility
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

### I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

### I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
    - Call Customer Care at the numbers at the bottom of the page.
    - Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.
- **Contact the Quality Improvement Organization.**
    - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
    - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

***Your deadline for contacting this organization***

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.

- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.
- If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 193 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 the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.

**What happens during a fast-track appeal**

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage."**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at (877) 588-1123 (TTY: (855) 887-6668).

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 on page 193 to learn how to ask the DMHC for an Independent

Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

### I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an "Alternate Appeal" process.

Contact Customer Care at the numbers at the bottom of the page and ask us for a "fast review."

> The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- 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 appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

You may 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 F4 on page 193 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.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

**Level 3 Appeal**

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

**Level 4 Appeal**

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

**Level 5 Appeal**

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

## J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process. 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.

## J3. Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

### Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

**Level 5 Appeal**

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

## K. How to make a complaint

### K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

| Complaint | Example |
|---|---|
| **Quality of your medical care** | • You are unhappy with the quality of care, such as the care you got in the hospital. |
| **Respecting your privacy** | • You think that someone did not respect your right to privacy or shared confidential information about you. |
| **Disrespect, poor customer service, or other negative behaviors** | • A health care provider or staff was rude or disrespectful to you.<br>• Our staff treated you poorly.<br>• You think you are being pushed out of our plan. |

| Complaint | Example |
|---|---|
| **Accessibility and language assistance** | • You cannot physically access the health care services and facilities in a doctor or provider's office.<br>• Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).<br>• Your provider does not give you other reasonable accommodations you need and ask for. |
| **Waiting times** | • You have trouble getting an appointment or wait too long to get it.<br>• Doctors, pharmacists, or other health professionals, Customer Care, or other plan staff keep you waiting too long. |
| **Cleanliness** | • You think the clinic, hospital or doctor's office is not clean. |
| **Information you get from us** | • You think we failed to give you a notice or letter that you should have received.<br>• You think written information we sent you is too difficult to understand. |
| **Timeliness related to coverage decisions or appeals** | • You think we don't meet our deadlines for making a coverage decision or answering your appeal.<br>• You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.<br>• You don't think we sent your case to the Independent Review Organization on time. |

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our

plan. If you need help making an internal and/or external complaint, you can call Customer Care at (800) 452-4113.

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

## K2. Internal complaints

To make an internal complaint, call Customer Care at 1-800-452-4413 (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 make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, 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.
- Here’s how it works:
    - Step 1: File a Grievance

      To begin the process, call a Customer Care representative within 60 calendar days of the event and ask to file a grievance. You may also file a grievance in writing within 60 calendar days of the event by sending it to:

      Blue Shield TotalDual Plan
      Appeals & Grievances Department
      P.O. Box 927, Woodland Hills CA 91365-9856
      **FAX**: (916) 350-6510

      If contacting us by fax or by mail, please call us to request a **Blue Shield TotalDual Plan Appeals & Grievance Form**.

      We will send you a letter letting you know that we received the notice of your concern within 5 calendar days and give you the name of the person who is working on it. We will normally resolve it within 30 calendar days.

      If you ask for an “expedited grievance” because we decided not to give you a “fast decision” or “fast appeal”, we will forward your request to a medical director who was not involved in our original decision. We may ask if you

have additional information that was not available at the time you requested a "fast initial decision" or "fast appeal."

The medical director will review your request and decide if our original decision was appropriate. We will send you a letter with our decision within 24 hours of your request for an "expedited grievance."

We must address your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint.

- Step 2: Grievance Hearing

  If you are not satisfied with the resolution of your grievance related to a quality of care issue, you may make a written request to the Blue Shield Medicare Appeals & Grievances Department for a grievance hearing. Within 31 calendar days of your written request, we will assemble a panel to hear your case. You will be invited to attend the hearing, which includes an uninvolved physician and a representative from the Appeals and Grievance Resolution Department. You may attend in person or by teleconference. After the hearing, we will send you a final resolution letter.

- If you are not satisfied with the resolution of your grievance that does not include quality of care, such as waiting times, disrespect, customer service or cleanliness, you may contact the Blue Shield TotalDual Plan Customer Care Department to request an additional review.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

## K3. External complaints

### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

You do not need to file a complaint with Blue Shield TotalDual Plan before filing a complaint with Medicare.

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

If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

### Medi-Cal

**You can file a complaint with the California Department of health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.**

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. 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 TTY number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care’s website (www.dmhc.ca.gov).

**Office for Civil Rights**

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 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.

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 Medi-Cal Ombuds Program for assistance. The phone number is 1-888-452-8609.

***Quality Improvement Organization***

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we 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 **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In California, the Quality Improvement Organization is called Livanta. Their phone number is (877) 588-1123 (TTY: (855) 887-6668.

# Chapter 10: Ending your membership in our plan

## Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

## Table of Contents

## A. When you can end your membership with our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you may be able to end your membership with our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The Annual Enrollment Period, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The Medicare Advantage Open Enrollment Period, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, or
- If you recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medi-Cal services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Customer Care at the numbers at the bottom of the page.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.
- Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail MMCDOmbudsmanOffice@dhcs.ca.gov.

**NOTE:** If you're in a drug management program, you may not be able to change plans. *Refer to Chapter 5 of your Member Handbook for information about drug management programs.*

## B. How to end your membership in our plan

You have the following options if you want to leave our plan:

- 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 237.
- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

## C. How to get Medicare and Medi-Cal services

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

## C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

| **1. You can change to:** | **Here is what to do:** |
|---|---|
| **Another Medicare health plan** including a plan that combines your Medicare and Medi-Cal coverage. | 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.<br><br>For PACE inquiries, call 1-855-921-PACE (7223).<br><br>If you need help or more information:<br><br>• 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/.<br><br>**OR**<br><br>Enroll in a new Medicare plan.<br><br>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. Your Medi-Cal plan may change. |

| | |
|---|---|
| **2. You can change to:**<br><br>**Original Medicare with a separate Medicare prescription drug plan** | **Here is what to do:**<br><br>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.<br><br>If you need help or more information:<br><br>• 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/.<br><br>**OR**<br><br>Enroll in a new Medicare prescription drug plan.<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins.<br><br>Your Medi-Cal plan will not change. |

| | |
|---|---|
| **3. You can change to:**<br><br>**Original Medicare without a separate Medicare prescription drug plan**<br><br>**NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.<br><br>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:**<br><br>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.<br><br>If you need help or more information:<br><br>• 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/.<br><br>You are automatically disenrolled from our plan when your Original Medicare coverage begins.<br><br>Your Medi-Cal plan will not change. |

### *C2. Your Medi-Cal services*

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

## D. How to get your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network pharmacies including through our mail service pharmacy to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Blue Shield TotalDual Plan ends, our plan will cover your hospital stay until you are discharged.

## E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Medi-Cal (Medicaid). Our plan is only for people who qualify for both Medicare and Medi-Cal (Medicaid).
    - Medicare beneficiaries that enroll in the Blue Shield TotalDual Plan must be eligible for both Medicare Part A and Part B and Medi-Cal (Medicaid). If you are no longer eligible for Medi-Cal (Medicaid), we will notify you of the loss of Medi-Cal (Medicaid) status and we will continue to cover your Medicare benefits until you are able to re-qualify for Medi-Cal (Medicaid) within the next 6 months after notification of loss of special needs status.
    - We extend the opportunity to switch to one of our non-HMO D-SNP plans. The non-HMO D-SNP plan is offered to beneficiaries who are entitled to both Medicare Part A and Medicare Part B, but do not have Medi-Cal (Medicaid) benefits. Medicare allows a Special Enrollment Period (SEP) for Medicare beneficiaries who are no longer eligible for Medi-Cal (Medicaid).
    - If you do not re-qualify for Medi-Cal (Medicaid) or accept the opportunity to switch to a non-HMO D-SNP plan within the six (6) months after notification of loss of special needs status, you will be involuntarily disenrolled from Blue Shield TotalDual Plan.
- If you move out of our service area.
- If you are away from our service area for more than six months. If you move or take a long trip, call Customer Care to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for 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 notify us if you're not eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

## F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

## G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

# Chapter 11: Legal notices

## Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook.*

## Table of Contents

## 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 the *Member Handbook*. The main laws that apply are federal and state laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

## B. 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, sex, or sexual orientation. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call the Department of Health Care Services, Office for Civil Rights at 916-440-7370. TTY users can call 711 (Telecommunications Relay Service).
- Send an email to CivilRights@dhcs.ca.gov.
- Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413
  Complaint forms are available at:
  www.dhcs.ca.gov/Pages/Language_Access.aspx

If you believe that you have been discriminated against and want to file a discrimination grievance, contact Customer Care. If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local

Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

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

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

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

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

If you have a disability and need help accessing health care services or a provider, call Customer 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 must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.

## D. Administration of the Evidence of Coverage

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this Evidence of Coverage.

## E. Member cooperation

You must complete any applications, forms, statements, releases, authorizations, lien forms and any other documents that we request in the normal course of business or as specified in this Evidence of Coverage.

## F. Assignment

You may not assign this Evidence of Coverage or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

## G. Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services we may recover the value of the services from the employer.

## H. Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

## I. U.S. Department of Veterans Affairs

For any services for conditions that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such services we may recover the value of the services from the Department of Veterans Affairs.

## J. Worker's compensation or employer's liability benefits

You may be eligible for payments or other benefits under workers' compensation or employer's liability law. We will provide covered Part D drugs even if it is unclear whether you are entitled to benefits, but we may recover the value of any Covered Services from the following sources:

1. From any source providing benefits or from whom a benefit is due.

2. From you, to the extent that a benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the benefits under any workers' compensation or employer's liability law.

## K. Overpayment recovery

We may recover any overpayment that we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

## L. When a third party causes your injuries

If you are injured or becomes ill due to the act or omission of another person (a "third party"), Blue Shield shall, with respect to Services required as a result of that injury, provide the Benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Blue Shield paid for Services provided to you from any recovery (defined below) obtained by or on behalf of you, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery you receive as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "Recovery"), without regard to whether you have been "made whole" by the Recovery. The right to restitution, reimbursement or other available remedy is with respect to that portion of the total Recovery that is due for the Benefits paid in connection with such injury or illness, calculated in accordance with California Civil Code Section 3040.

You are required to:

1. Notify Blue Shield in writing of any actual or potential claim or legal action which you expect to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than 30 days after submitting or filing a claim or legal action against the third party; and,

2. Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies; and,

3. Agree in writing to reimburse Blue Shield for Benefits paid by Blue Shield from any Recovery when the Recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage; and,

4. Provide a lien calculated in accordance with the California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Periodically respond to information requests regarding the claim against the third party, and notify Blue Shield, in writing, within ten (10) days after any Recovery has been obtained.

Your failure to comply with 1. Through 5., above shall not in any way act as a waiver, release, or relinquishment of the rights of Blue Shield.

## M. Notice about Health Information Exchange Participation

Blue Shield participates in the **Manifest MedEx** Health Information Exchange ("HIE") making its members' health information available to Manifest MedEx for access by their authorized health care providers. Manifest MedEx is an independent, not-for-profit organization that maintains a statewide database of electronic patient records that includes health information contributed by doctors, health care facilities, health care service plans, and health insurance companies. Authorized health care providers (including doctors, nurses, and hospitals) may securely access their patients' health information through the Manifest MedEx HIE to support the provision of safe, high-quality care.

Manifest MedEx respects Members' right to privacy and follows applicable state and federal privacy laws. Manifest MedEx uses advanced security systems and modern data encryption techniques to protect Members' privacy and the security of their personal information.

Every Blue Shield Member has the right to direct Manifest MedEx not to share their health information with their health care providers. Although opting out of Manifest MedEx may limit your health care provider's ability to quickly access important health care information about you, a member's health insurance or health plan benefit coverage will not be affected by an election to opt-out of Manifest MedEx. No doctor or hospital participating in Manifest MedEx will deny medical care to a patient who chooses not to participate in the Manifest MedEx HIE.

Members who do not wish to have their healthcare information displayed in Manifest MedEx should fill out the online form at https://www.manifestmedex.org/opt-out or call

Manifest MedEx at (888) 510-7142, 7 a.m. to 7 p.m. PST, Monday through Friday. TTY 711 for the hearing impaired.

## N. Reporting Fraud, Waste, and Abuse

**What is fraud, waste, and abuse (FWA)?**

- **Fraud** is an intentional misrepresentation that may result in unauthorized costs to a healthcare program.
- **Waste** is the inappropriate use of healthcare funds or resources without a justifiable need to do so.
- **Abuse** is a practice that is inconsistent with sound medical or business practices that may directly or indirectly result in unnecessary costs to a healthcare program.

**Protect yourself and your benefits**

- Never give out your Social Security, Medicare or health plan numbers or banking information to someone you don't know.
- Do not consent to any lab tests without your doctor's order.
- It is illegal to accept anything of value in exchange for medical services.

**Be aware of genetic testing fraud**
Scammers approach unsuspecting enrollees at local health fairs, senior housing facilities, community centers, home health agencies, and other trustworthy locations to carry out genetic testing fraud. They falsely promise that Medicare will pay for the test, and you simply need to provide a cheek swab, your ID, and Medicare information in order to receive your test results.

Unfortunately, now these scammers have your health plan or Medicare number, and they can bill Medicare thousands of dollars for tests or even services that you never receive. They also have your personal genetic information.

To report suspected fraud, waste, and abuse, please contact:

- **Blue Shield of California's Medicare fraud hotline: (855) 331-4894 (TTY: 711)** or via email: MedicareStopFraud@blueshieldca.com.

- **Medicare at 1-800 MEDICARE (1-800-633-4227),** 24 hours a day, seven days a week (TTY users should call 1-877-486-2048.

# Chapter 12: Definitions of important words

## Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Care.

**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.

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 of your Member Handbook explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use 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.

**Care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

**Care plan: Refer to "Individualized Care Plan."**

**Care Plan Optional Services (CPO Services):** Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Medi-Cal.

**Care team: Refer to "Interdisciplinary Care Team."**

**Catastrophic coverage stage:** The stage in the Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you reach the $7,400 limit for your prescription drugs.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. Chapter 2 of your *Member Handbook* explains how to contact CMS.

**Community-Based Adult Services (CBAS):** Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy**, speech therapy, and home environment evaluation services.**

**Copay:** A fixed amount you pay as your share of the cost each time you get certain services or prescription drugs. For example, you might pay $2 or $5 for a service or a prescription drug.

**Cost sharing:** Amounts you have to pay when you get certain services or 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 five 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 pay for your health services. Chapter 9 *of your Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

**Customer Care:** A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Care.

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**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 is 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 Medi-Cal (Medicaid) Program (known as Medi-Cal).

**Department of Managed Health Care (DMHC):** The state department in California responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of five tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medi-Cal. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be a serious injury or severe pain.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

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

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health Insurance Counseling and Advocacy Program (HICAP):** A program that provides free and objective information and counseling about Medicare. Chapter 2 of your *Member Handbook* explains how to contact HICAP.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

**Home health aide:** A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has 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.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Customer Care if you get any bills you don't understand. **As a plan member, you only pay our plan's cost sharing amounts when you get services we cover. 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 make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

**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 $4,660. This includes amounts you paid, what our plan 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, we pay part of the costs of your drugs, and you pay your share.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

***List of Covered Drugs*** **(Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing home or hospital. LTSS include Community Based Adult Services (CBAS) and Nursing Facilities (NF).

**Low-income subsidy (LIS):** Refer to "Extra Help."

**Mail Service Program**: Some plans may offer a mail service program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

**Medi-Cal:** This is the name of California'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.
- Medi-Cal (Medicaid) programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal (Medicaid).
- Refer to **Chapter 2** of your *Member Handbook* 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.

**Medicare:** The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA,” that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare-covered services:** Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Part B.

**Medicare-Medi-Cal enrollee:** 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 (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA” that lets private health insurance companies provide Medicare benefits through 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. Our plan includes Medicare Part D.

**Medicare Part D drugs**: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Part D. Medi-Cal may cover some of these drugs.

**Medication Therapy Management**: A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to Chapter 5 of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Network pharmacy:** A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

**Network provider:** "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports**.**

- They are licensed or certified by Medicare and by the state to provide health care services.

- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.

- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

**Nursing home or facility:** A place that provides care for people who can't get their care at home but don't need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information in Chapters 2 and 9 of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, make a decision about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” Chapter 9 **of your Member Handbook** explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility**: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 of your Member Handbook explains out-of-network providers or facilities.

**Out-of-pocket costs**: **T**he 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 are drugs or medicines that a person can buy without a prescription from a health care professional.

**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

**Part D:** Refer to “Medicare Part D.”

**Part D drugs:** Refer to “Medicare Part D drugs.”

**Personal health information (also called Protected health information) (PHI):** Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

**Primary care physician (PCP):** The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.

- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.

- Refer to Chapter *3* of your Member Handbook for information about getting care from primary care providers.

**Prior authorization:** An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets prior authorization from us.

- Covered services that need our plan's prior authorization are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs 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):** 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:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to Chapter 2 of your Member Handbook for information about the QIO**.**

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in Chapters 3 and 4 of your Member Handbook.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 of your *Member Handbook* to learn more about rehabilitation services.

**Sensitive services:** Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

**Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing **facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.**

**Specialist:** A doctor who provides health care for a specific disease or part of the body.

**Specialized pharmacy:** Refer to Chapter 5 of your *Member Handbook* to learn more about specialized pharmacies.

**State Hearing:** If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. SSI automatically provides Medi-Cal coverage.

**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 TotalDual Plan Customer Care

| | |
|---|---|
| **CALL** | (800) 452-4413<br>Calls to this number are free. 8 a.m. to 8 p.m., seven days a week, days a week.<br>Customer Care also has free language interpreter services available for non-English speakers. |
| **TTY** | 711<br>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.<br>Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. |
| **FAX** | (877) 251-6671 |
| **WRITE** | Blue Shield TotalDual Plan<br>P.O. Box 927, Woodland Hills, CA 91365-9856 |
| **WEBSITE** | www.blueshieldca.com/medicare |

blue california

## NONDISCRIMINATION NOTICE

Discrimination is against the law. Blue Shield of California complies with applicable state laws and federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Blue Shield of California 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 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 Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007
Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@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**.

blue california

## MULTI-LANGUAGE INSERT

**English** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-452-4413. Someone who speaks English can help you. This is a free service.

**Spanish** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-452-4413. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Mandarin** 我们提供免费的翻译服务，**帮**助**您**解答**关**于健康或药物保险的任何疑 问。如果**您**需要此翻译服务，请致电 1-800-452-4413。我们的中文工作人员很乐意**帮**助**您**。 这是一项免费服务。

**Cantonese** **您**對我們的健康或藥物保險可能存有疑問，**為**此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-452-4413。我們講中文的人員將樂意**為您**提供幫助。這 是一項免費服務。

**Tagalog** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-452-4413. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-452-4413. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-452-4413 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

**German** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-452-4413. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-452-4413 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-452-4413. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن اي اسئلة تتعلق بالصحة او جدول الادوية لدينا. للحصول

ليس عليك سوى الاتصال بنا على 1-800-452-4413. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية على مترجم فوري،

**Hindi** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-452-4413 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian** E disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-452-4413. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-452-4413. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an.  Pou jwenn yon entèprèt, jis rele nou nan 1-800-452-4413.  Yon moun ki pale Kreyòl kapab ede w.  Sa a se yon sèvis ki gratis.

**Polish** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-452-4413. Ta usługa jest bezpłatna.

**Japanese** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サ—ビスがありますございます。通訳をご用命になるには、1-800-452-4413 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサ— ビスです。

**Hmong** Peb muaj cov kev pab cuam txhais lus pab dawb los teb tej lus nug uas koj muaj hais txog ntawm peb li kev noj qab haus huv los sis lub phiaj xwm tshuaj kho mob. Kom tau txais tus kws pab cuam txhais lus, tsuas yog hu rau peb ntawm 1-800-452-4413. Muaj cov paub lus Hmoob tuaj yeem pab tau koj. Qhov no yog pab dawb.

**Ukrainian** Ми надаємо безкоштовні послуги перекладача, щоб відповісти на будь-які запитання щодо нашого плану лікування чи надання лікарських засобів. Щоб скористатися послугами перекладача, просто зателефонуйте нам за номером 1-800-452-4413. Вам може допомогти хтось, хто розмовляє Українською. Це безкоштовна послуга.

**Navajo** D77 ats’77s baa 1h1y3 47 doodago azee’ bee aa 1h1y3 b7na’7d7[kidgo 47 n1 ata’ hodoolnih77 h0l=. Ata’ halne’4 biniiy4go, koj8’ 1-800-452-4413 b44sh bee hod77lnih. Diné k’ehj7 y1[ti’i n7k1 adoolwo[. D77 t’11 j77k’eh bee an1’1wo.

**Punjabi** ਪੰਜਾਬੀ ਸਾਡੀ ਸਿਹਤ ਜਾਂ ਡਰੱਗ ਪਲਾਨ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਲਈ ਸਾਡੇ ਕੋਲ ਮੁਫ਼ਤ ਦੁਭਾਸ਼ੀਏ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਲੈਣ ਲਈ, ਸਾਨੂੰ 1-800-452-4413 'ਤੇ ਕਾਲ ਕਰੋ। ਪੰਜਾਬੀ ਬੋਲਣ ਵਾਲਾ ਕੋਈ ਵੀ ਵਿਅਕਤੀ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਇਹ ਇੱਕ ਮੁਫ਼ਤ ਸੇਵਾ ਹੈ।

**Khmer** យើងមានសេវាអ្នកបកប្រែផ្តាល់មាត់ដោយឥតគិតថ្លៃដើម្បីឆ្លើយសំណួរនានា ដែលអ្នកអាចមានអំពីសុខភាព ឬគម្រោងឱសថរបស់យើង។ ដើម្បីទទួលបានអ្នកបកប្រែផ្តាល់មាត់ម្នាក់ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខ 1-800-452-4413។ អ្នកណាម្នាក់ដែលនិយាយភាសាខ្មែរអាចជួយអ្នកបាន។ សេវានេះមិនគិតថ្លៃនោះទេ។

**Mien** Yie mbuo mbenc duqv maaih tengx wang-henh nzie faan waac mienh liouh dau waac bun muangx dongh nzunc baav meih maaih waac naaic taux yie mbuo gorngv taux yie nyei heng-wangc jauv-louc a’fai ndie-daan.  Liouh lorx zipv longc faan waac nor, douc waac lorx taux yie mbuo yiem njiec naaiv 1-800-452-4413. Maaih mienh gorngv benx Mienh waac haih tengx nzie duqv meih.  Naaiv se benx wang-henh nzie weih jauv-louc oc.

**Lao** ພວກເຮົາມີບາຍພາສາໂດຍບໍ່ເສຍຄ່າເພື່ອຕອບຄຳຖາມຕ່າງໆທີ່ທ່ານອາດຈະມີກ່ຽວກັບສຸຂະພາບ ຫຼື ແຜນການຢາຂອງພວກເຮົາ. ເພື່ອໃຫ້ໄດ້ຮັບບາຍພາສາ, ພຽງແຕ່ໂທຫາພວກເຮົາທີ່ເບີ 1-800-452-4413. ມີຜູ້ຮູ້ ພາສາລາວ ສາມາດຊ່ວຍທ່ານ. ນີ້ແມ່ນບໍລິການໂດຍບໍ່ເສຍຄ່າ.

**Armenian** Մեզ մոտ հասանելի են անվճար թարգմանչական ծառայություններ՝ մեր առողջապահական կամ դեղերի պլանի հետ կապված ձեր ցանկացած հարցին պատասխանելու համար: Թարգմանիչ ունենալու համար պարզապես զանգահարեք մեզ 1-800-452-4413 հեռախոսահամարով: Ձեզ կօգնի հայերեն խմացող թարգմանիչը: Ծառայությունն անվճար է:

**Farsi** ما خدمات مترجم شفاهی رایگان ارائه می‌دهیم تا به هر گونه سؤالی که در مورد طرح سلامت یا داروی ما دارید پاسخ دهیم. برای داشتن مترجم شفاهی، کافیست با ما به شماره 1-800-452-4413 تماس بگیرید. کسی که فارسی صحبت می‌کند می‌تواند به شما کمک کند. این یک خدمت رایگان است.

**Thai** ภาษาไทย เรามีบริการล่ามฟรีเพื่อตอบคำถามของคุณเกี่ยวกับสุขภาพหรือแผนด้านยาของคุณ หากต้องการบริการล่าม โปรดโทรหาเราที่ 1-800-452-4413 มีคนที่สามารถพูดภาษาไทยได้เพื่อช่วยเหลือคุณ บริการนี้เป็นบริการฟรี

blue california

# LANGUAGE ASSISTANCE NOTICE

**English** ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-452-4413 (TTY: 711), 8:00 a.m. to 8:00 p.m., seven days a week. The call is free.

**中文 Chinese** 请留意：如果您说中文，可以免费获得语言协助服务。请拨打 1-800-452-4413 (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。

**한국어 Korean** 주: 귀하가 한국어를 사용하시는 경우, 무료로 언어 지원 서비스를 이용하실 수 있습니다. 1-800-452-4413 (TTY: 711)번으로 주 7 일, 오전 8 시부터 오후 8 시까지 전화하실 수 있습니다. 이 전화는 무료입니다.

**Русский Russian** ОБРАТИТЕ ВНИМАНИЕ! Если Вы говорите по-русски, мы можем предложить Вам бесплатные услуги языковой поддержки. Звоните по телефону 1-800-452-4413 (TTY: 711) с 8:00 до 20:00 без выходных. Звонок бесплатный.

**فارسیFarsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات امداد زبانی بدون اخذ هزینه در اختیار شما می باشد. با شماره 1-800-452- 4413 (TTY: 711)، از ساعت 8:00 صبح تا 8:00 شب در هفت روز هفته تماس بگیرید. این تماس رایگان است.

**भाषा Hindi** ध्यान: यदि आप भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। फ़ोन करना 1-800-452-4413 (TTY: 711), सुबह 8:00 बजे से शाम 8:00 बजे तक, सप्ताह के सातों दिन। फ़ोन करना फ्री है।

Lus Hmoob **Hmong** LUS CEEV: Yog koj hais Lus Hmoob, muaj kev pab txhais lus pub dawb rau koj.Hu rau 1-800-452-4413 (TTY: 711), 8:00 teev sawv ntxov txog 8:00 teev tsaus ntuj, xya hnub hauv ib lub as thiv.Qhov hu xov tooj no yog hu dawb xwb.

Español **Spanish** ATENCIÓN: Si usted habla español, hay a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-800-452-4413 (TTY: 711), de 8:00 a.m. a 8:00 p.m., los siete días de la semana. La llamada es gratuita.

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 1-800-452-4413 (TTY: 711), 8 giờ sáng đến 8 giờ tối, bảy ngày trong tuần. Cuộc gọi này miễn phí.

**Tagalog** PAUNAWA: Kung nagsasalita kayo ng Tagalog, may mga available na libreng serbisyo ng tulong sa wika para sa inyo. Tumawag sa 1-800-452-4413 (TTY: 711), 8:00 a.m. hanggang 8:00 p.m., pitong araw sa isang linggo. Libre ang tawag.

**العربية Arabic**
تنبيه: إذا كنت تتحدث اللغة العربية، يتوفر لك خدمات المساعدة اللغوية المجانية. اتصل على الرقم 1-800-452-4413 (TTY: 711)، من الساعة 8:00 صباحًا إلى 8:00 مساءً طوال أيام الأسبوع. علمًا بأن هذه المكالمة مجانية.

**ພາສາລາວ Laotian** ຂໍ້ຄວນລະວັງ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທຫາ 1-800-452-4413 (TTY: 711), 8:00 ໂມງເຊົ້າ ຫາ 8:00 ໂມງແລງ, ເຈັດວັນຕໍ່ອາທິດ.
ການໂທແມ່ນບໍ່ເສຍຄ່າ.

**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。1-800-452-4413 (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。

**ภาษาไทย Thai**
**เรียน หากคุณพูดภาษา ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาให้แก่คุณโดยไม่มีค่าใช้จ่าย โทร 1-800-452-4413 (TTY: 711) 8:00 น. ถึง 20:00 น. ได้ตลอดเจ็ดวันต่อสัปดาห์ โทรฟรี ไม่มีค่าใช้จ่าย**

**ਪੰਜਾਬੀ Punjabi** ਸਾਵਧਾਨ : ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ, ਉਪਲਬਧ ਹਨ | ਕਾਲ ਕਰੋ 1-800-452-4413 (TTY: 711), ਸਵੇਰੇ 8:00 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8:00 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ ਸੱਤ ਦਿਨ ਹਫ਼ਤੇ ਦੇ ਸੱਤ ਦਿਨ. ਕਾਲ ਫ੍ਰੀ ਹੈ |

**ខ្មែរ Khmer**ចាប់អារម្មណ៍៖ បើសិនអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសា គឺមានសំរាប់អ្នក ដោយឥតគិតថ្លៃ។ ហៅ 1-800-452-4413 (TTY: 711) ម៉ោង 8:00 ព្រឹក ដល់ 8:00 យប់ ប្រាំពីរថ្ងៃមួយអាទិត្យ។ គឺឥតគិតថ្លៃទេ។

**Հայերեն Armenian** ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, Ձեզ տրամադրելի են անվճար լեզվական օգնության ծառայություններ: Զանգահարեք 1-800-452-4413 (TTY՝ 711) համարով, 8:00-ից 20:00, շաբաթը յոթ օր: Հեռախոսազանգն անվճար է:

**Українська Ukrainian** ЗВЕРНІТЬ УВАГУ! Якщо Ви розмовляєте українською, ми можемо запропонувати Вам безкоштовні послуги мовної підтримки. Телефонуйте 1-800-452-4413 (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 1-800-452-4413 (TTY: 711), 8:00 diemv ziangh hoc lungh ndorm mingh taux 8:00 ziangh hoc lungh 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.

Blue Shield of California 6300 Canoga Avenue, Woodland Hills, CA 91367-2555