



L.A. Care
Medicare Plus[™]
(HMO D-SNP)

Member Handbook 2023

January 1, 2023 - December 31, 2023



L.A. Care Medicare Plus (HMO D-SNP) Member Handbook

January 1, 2023 – December 31, 2023

Your Health and Drug Coverage under L.A. Care Medicare Plus

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 L.A. Care Medicare Plus.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free.

ATENCIÓN: Si usted habla español, los servicios de asistencia con el idioma estarán disponibles para usted sin costo. Llame al 1-833-522-3767 (TTY: 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.

ध्यान दें: अगर आप हिंदी बोलते हैं, तो मुफ्त में भाषा सहायता सेवाएं, आपके लिए उपलब्ध हैं। अवकाश के दिनों समेत, दिन के 24 घंटे, सप्ताह के 7 दिन 1-833-522-3767 (TTY: 711) पर कॉल करें। कॉल नि:शुल्क है।

LUS TSHAJ TAWM: Yog koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj, hu rau 1-833-522-3767 (TTY: 711), 24 teev hauv ib hnuv, 7 hnuv hauv ib asthiv, suav nrog cov hnuv so tib si. Qhov hu no yog hu dawb xwb.

ព័ត៌មានអំពីសេវាសុខភាព និងសេវាគ្រប់គ្រងជំងឺ អាចរកបាននៅលើគេហទំព័រ ឬទូរស័ព្ទលេខ 1-833-522-3767 (TTY: 711) រាល់ថ្ងៃ 24 ម៉ោង ៧ ថ្ងៃក្នុងមួយសប្តាហ៍ រួមទាំងថ្ងៃឈប់សម្រាក។ ការហៅទូរស័ព្ទនេះគឺមិនគិតថ្លៃទេ។

ចំណាំ: បើអ្នកនិយាយភាសា ខ្មែរ, សេវាជំនួយផ្នែកភាសា គ្មានបង់ថ្លៃ គឺមានសម្រាប់ជួយអ្នក។ សូមទូរស័ព្ទទៅ 1-833-522-3767 (TTY: 711), 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍រួមទាំងថ្ងៃឈប់សម្រាក។ ការហៅទូរស័ព្ទនេះគឺមិនគិតថ្លៃទេ។



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

안내: 한국어를 사용하실 경우 언어지원서비스를 무료로 이용하실 수 있습니다. 연중무휴로 이용할 수 있는 1-833-522-3767 (TTY: 711) 번으로 전화하십시오. 통화료는 무료입니다.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਛੁੱਟੀ ਵਾਲੇ ਦਿਨਾਂ ਸਮੇਤ 24 ਘੰਟੇ, 7 ਦਿਨ 1-833-522-3767 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ। ਕਾਲ ਮੁਫਤ ਹੈ।

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສັຽຄ່າ. ໂທ 1-833-522-3767 (TTY: 711), ໄດ້ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ, ລວມເຖິງ ວັນພັກ ຕ່າງໆ. ເບີໂທນີ້ແມ່ນບໍ່ເສັຽຄ່າ.

ВНИМАНИЕ! Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами переводчика. Звоните по телефону 1-833-522-3767 (TTY: 711), круглосуточно, без выходных, включая праздничные дни. Звонок бесплатный.

โปรดทราบ: หากท่านพูดภาษาไทย เรามีบริการช่วยเหลือด้านภาษาให้คุณโดยไม่เสียค่าใช้จ่าย โปรดโทรฟรีที่หมายเลข 1-833-522-3767 (TTY: 711) ได้ตลอด 24 ชั่วโมง ทุกวัน ไม่เว้นวันหยุด

PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-833-522-3767 (TTY: 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kabilang ang mga piyesta opisyal. Libre ang pagtawag.

CHÚ Ý: Nếu quý vị nói Tiếng Việt, hiện có các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi 1-833-522-3767 (TTY: 711), 24 giờ một ngày, 7 ngày một tuần, kể cả các ngày lễ. Cuộc gọi là miễn phí.

注意：如果您說中文，您可免費獲得語言協助服務。請致電 1-833-522-3767 (TTY: 711)，服務時間為每週 7 天，每天 24 小時（包含假日）。這是免費電話。

عناية: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجاناً. اتصل على 1-833-522-3767 (TTY: 711)، 24 ساعة في اليوم و 7 أيام في الأسبوع، بما في ذلك أيام العطلات. هذه المكالمات مجانية.

ت وجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان بطور رایگان در اختیار شما قرار دارد. می توانید در تمام 24 ساعت شبانه روز و 7 روز هفته، حتی روزهای تعطیل با 1-833-522-3767 (TTY: 711) تماس بگیرید. تماس رایگان می باشد.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free.

If you want to receive materials, now and in the future, in a language other than English or in an alternative format, call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free.



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Disclaimers

- ❖ L.A. Care Medicare Plus (HMO D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Enrollment in L.A. Care Medicare Plus depends on contract renewal.
- ❖ Coverage under L.A. Care Medicare Plus 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about L.A. Care Medicare Plus, 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*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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 Managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

L.A. Care Medicare Plus is a Medicare Medi-Cal Plan (MMP or Medi-Medi plan), which is an Exclusively Aligned Enrollment Dual Eligible Special Needs Plan offered by L.A. Care Health Plan.

L.A. Care Health Plan is a public entity whose official name is the Local Initiative Health Authority for Los Angeles County. L.A. Care Health Plan is an independent, publicly managed health plan, licensed by the State of California. L.A. Care Health Plan works with doctors, clinics, hospitals, and other providers to offer you quality health care services.

B. Information about Medicare and Medi-Cal

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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 Manager. 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 Manager.
- Your care team and Care Manager 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 L.A. Care Medicare Plus: In most instances you will be enrolled in L.A. Care Medicare Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in L.A. Care Medicare Plus. 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 L.A. Care Medicare Plus. There will be no gap in your Medi-Cal coverage. Please call us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays if you have any questions.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

D. Our plan's service area

Our service area includes all parts of Los Angeles.

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 Member Services for more information.

Please note: if you lose your eligibility but can reasonably be expected to regain eligibility within 3 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 includes 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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 L.A. Care Medicare Plus 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. When you select a primary care provider (PCP), you will be assigned to the medical group affiliated with that provider. A primary care provider is the doctor or other provider you see first for most health problems. A medical group is an association of PCPs and specialists created to provide coordinated health services. 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 Manager, or other health person that you choose.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

A care coordinator is a person trained to help you manage the care you need. You get a Care Manager 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 Manager 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 premium for L.A. Care Medicare Plus is \$38.90.

The “Extra Help” program helps people with limited resources pay for their drugs. If you qualify, enrolling in the program might lower your monthly plan premium. If you are already enrolled and getting help from one of these programs, the information about premiums in this Evidence of Coverage may not apply to you. We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays) and ask for the “LIS Rider.”



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

I. Your Member Handbook

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

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* 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 Member Services 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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

- Specialty Mental Health
- Substance Use Disorder
- Dental
- Medical-Cal Rx

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 Member Services 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 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 L.A. Care Medicare Plus member. We also list the pharmacies that you may use to get your prescription drugs. Contact Member Services for information about network providers, such as name, address, telephone numbers, professional qualifications, specialty, medical school attended, residency completion and board certification status.

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

Definition of network pharmacies

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

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

J3. List of Covered Drugs

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

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

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

K. Keeping your membership record up to date

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Member Services.

You can also make information changes using your online L.A. Care Connect account. L.A. Care Connect is an online account available for L.A. Care Medicare Plus members who register. You can register and access your L.A. Care Connect account by visiting **www.medicare.lacare.org**. After registering, you can sign in to do the following:

- View your eligibility and benefits
- Request, view, and/or print your ID card
- Change your Doctor or Medical Group
- Manage your medications, view your medication history, find a pharmacy, and access all other Pharmacy benefits
- Participate in available wellness programs

K1. Privacy of personal health information (PHI)

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

A. Member Services

CALL	1-833-522-3767 This call is free. 24 hours a day, 7 days a week, including holidays. You can get this information for free in other formats, such as large print, braille and/or audio by calling the number above. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, including holidays
FAX	1-213-438-5712
WRITE	L.A. Care Medicare Plus Attn: Member Services Department 1055 West 7th Street 10th Floor Los Angeles, CA 90017
WEBSITE	medicare.lacare.org/

Contact Member Services to get help with:

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 from us or to the Quality Improvement Organization (refer to **Section F**).
 - You can call us and explain your complaint at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.
 - 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 1-888-452-8609, (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m.
 - 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*.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

B. Your Care Manager

What is a Care Manager?

- A Care Manager is a nurse or health professional who will get to know you and understand your health needs. Your Care Manager works in a team with you, your doctor(s), caregivers, and others involved in your health care. The Care Manager assesses what services you need, makes a care plan with you to identify services you need, coordinates your services, and follows up to see how things are going.

You can contact the Care Manager to help answer questions and find the right resources to make sure you stay as healthy as possible.

How can you contact your Care Manager?

- You can contact Member Services at the numbers listed below. They will connect you to the Care Coordination/Care Management department.

How can you change your Care Manager?

- Contact Member Services at 1-833-522-3767 (TTY: 711) 24 hours a day, 7 days a week, including holidays.

CALL	1-833-522-3767 This call is free. 24 hours a day, 7 days a week, including holidays. You can get this information for free in other formats, such as large print, braille and/or audio by calling the number above. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week, including holidays
FAX	1-213-438-5712
WRITE	L.A. Care Medicare Plus Attn: Member Services Department 1055 West 7 th Street Los Angeles, CA 90017
WEBSITE	medicare.lacare.org/

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



Contact your Care Manager to get help with:

- Questions about your health care
- Questions about getting behavioral health (mental health and substance use disorder) services
- Questions about services and supports to help you stay healthy

MLTSS include Community-Based Adult Services (CBAS), Long Term Care (LTC), In-Home Supportive Services and Nursing Facilities (NF).

Members must meet certain eligibility requirements to qualify for each of these programs. Call L.A. Care Medicare Plus MLTSS Department at 1-855-427-1223 (TTY: 711), Monday – Friday, 8 a.m. to 5 p.m., excluding holidays for additional information on eligibility requirements. 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),
- Long Term Care (LTC) in a nursing facility,
- In-Home Supportive Services (IHSS),
- Personal Care and Homemaker Services,
- Respite Care,
- Home Modification



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

C. Nurse Advice Call Line

You can call the Nurse Advice Line 24 hours a day, 7 days a week for any health related question. Our nurses are trained professionals who can provide appropriate health information, education and advice, including helping you to get urgent or emergency level care. If you have specific questions about ongoing treatment, you should call your physician's office. Nurse Advice line does not replace your physician's office. You can contact the Nurse Advice Call Line with questions about your health or health care.

CALL	<p>1-800-249-3619 This call is free.</p> <p>24 hours a day, 7 days a week, including holidays. You can get this information for free in other formats, such as large print, braille and/or audio by calling the number above.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, including holidays</p>



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

D. Behavioral Health Crisis Line

L.A. Care Medicare Plus provides you with access to medical information and advice 24 hours a day, 7 days a week, including holidays. When you call, our Behavioral Health specialists will answer your wellness-related questions. If you have an urgent health need but it is not an emergency, you can call our Behavioral Health Services Line 24 hours a day, 7 days a week, including holidays for behavioral health clinical questions.

CALL	<p>1-877-344-2858 This call is free.</p> <p>24 hours a day, 7 days a week, including holidays. You can get this information for free in other formats, such as large print, braille and/or audio by calling the number above.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, including holidays</p>

Contact the Behavioral Health Services Line for help with:

- Questions about behavioral health and substance abuse services

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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	1-800-434-0222 Schedule an appointment to see a counselor at your local HICAP office
TTY	711 The call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	California Health Advocates 5380 Elvas Avenue, Suite 221 Sacramento, CA 95819
WEBSITE	www.cahealthadvocates.org/HICAP/

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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



F. Quality Improvement Organization (QIO)

Our state has an organization called Livanta Medicare 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 Medicare Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) is not connected with our plan.

CALL	1-877-588-1123 Monday-Friday, 9 a.m. – 5 p.m. Saturday, Sunday and Holidays, 11 a.m. – 3 p.m.
TTY	1-855-887-6668 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO Program 10820 Guilford Rd. Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

Contact Livanta Medicare 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

CALL	1-844-580-7272 Monday through Friday, 8 a.m. to 6 p.m.
TTY	1-800-430-7077 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
WEBSITE	www.healthcareoptions.dhcs.ca.gov/



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

J. County Social Services

If you need help with your In-Home Supportive Services (IHSS), Supplemental Security Income (SSI), Mental Health or Substance Abuse benefits, contact your local County Social Services Department.

CALL	1-866-613-3777 This call is free. Monday through Friday, excluding holidays, 7:30 a.m. to 5:30 p.m. The customer Service Center (CSC) is a “single point of contact” currently providing services to 33 District Offices for the following aid programs and languages: CalWORKs, CalFresh, Medi-Cal and General Relief, with services in Armenian, Cambodian, English, Spanish, Vietnamese, Chinese, Farsi, Tagalog, Russian and Korean.
TTY	711 The call is free. 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 12860 Crossroads Parkway South City of Industry, CA 91746
WEBSITE	http://dpss.lacounty.gov



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

CALL	<p>1-800-854-7771 This call is free.</p> <p>24 hours a day, 7 days a week, including holidays</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, including holidays</p>

Contact the county specialty mental health plan for help with:

- Questions about behavioral health services provide by the county
- The Los Angeles County Department of Mental Health provides specialty mental health services including outpatient mental health services, day treatment intensive crisis intervention and stabilization, targeted case management, screening, adult residential treatment and crisis residential treatment.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

L. California Department of Managed Health Care

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

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

L.A. County Department of Public Health/Substance Abuse Prevention & Control

Additional substance use disorder treatments are made available through L.A. County Department of Public Health/Substance Abuse Prevention & Control. This set of benefits includes day care rehabilitation, outpatient individual and group counseling and perinatal residential services. You may contact our L.A. County Department of Public Health/Substance Abuse Prevention & Control at 1-844-804-7500 (TTY: 711) for referrals and linkages.

How to contact the Department of Rehabilitation

The Department of Rehabilitation assists individuals with disabilities in areas of employment by providing vocational rehabilitation, training, and job placement services.

CALL: 1-800-952-5544 (TTY:1-844-729-2800)

WRITE: Department of Rehabilitation
P.O. Box 944222
Sacramento, CA
94244-2220

WEBSITE: www.dor.ca.gov

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



How to contact the Independent Living Centers (ILCs)

ILCs are organizations which provide services that enable individuals with disabilities to live and work independently in their communities. Services include attendant referrals, advocacy, peer counseling, and information related to housing and transportation. The seven Independent Living Centers (ILCs) in Los Angeles County are:

Communities Actively Living Independent & Free (CALIF)

CALL: 1-213-627-0477
 TTY: 1-213-623-9502
 FAX: 1-213-627-0535
 WRITE: Communities Actively Living Independent
 & Free (CALIF) 634 South Spring Street,
 2nd Floor
 Los Angeles, CA 90014
 WEBSITE <https://califilc1.wixsite.cm/>

Disabled Resources Center (DRC)

CALL: 1-562-427-1000
 TTY: 1-562-427-1366
 FAX: 1-562-427-2027
 WRITE: 2750 E. Spring Street, Ste. #100
 Long Beach, CA 90806
 WEBSITE: www.drcinc.org

Independent Living Center of Southern California (ILCSC)

CALL: 1-877-452-4227 or 1-818-785-6934
 TTY: 1-818-785-7097
 EMAIL: ilcsc@ilcsc.org
 WRITE: 14407 Gilmore Street, #101
 Van Nuys, CA 91401
 WEBSITE: www.ilcsc.org

Service Center for Independent Life (SCIL)

CALL: 1-800-491-6722;
 Claremont office: 1-909-621-6722
 TTY: 1-909-445-0726
 WRITE: SCIL Claremont Office
 107 S. Spring Street Claremont, CA 91711; or
 WEBSITE: www.scil-ilc.org



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

Southern California Resource Services for Independent Living (SCRS-IL)

CALL: Downey office: 1-562-862-6531; Pasadena office: 1-626-587-5010
 TTY: 1-562-869-0931
 FAX: Downey office: 1-562-923-5274; Pasadena office: 1-626-714-7068
 WRITE: Downey Office
 7831 Quill Drive, Ste. D Downey, CA 90242
 Pasadena Office
 2023 Lincoln Ave.
 Pasadena, CA 91103
 WEBSITE: www.scrs-ilc.org

How to contact the Regional Centers

Regional centers provide programs and coordinate services for individuals with developmental disabilities. California has 21 regional centers with more than 40 offices located throughout the state that serve individuals with developmental disabilities and their families. To access the directory of Regional Centers go to the website listed below.

CALL: 1-833-421-0061
 TTY: 711
 WRITE: P.O. Box 944202
 Sacramento, CA 94244-2020
 WEBSITE: www.dds.ca.gov

How to contact the Personal Assistance Services Council (PASC)

PASC is the public authority for In-Home Supportive Services (IHSS) in L.A. County. PASC provides services to enhance the quality of life for all people who receive and provide IHSS, including assistance with finding a homecare worker, temporary homecare worker assistance, and training opportunities for IHSS recipients and homecare workers.

CALL: 1-877-565-4477
 TTY: 1-626-737-7512
 FAX: 1-818-206-8000
 WEBSITE: www.pascla.org



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

How to contact the Area Agency on Aging (AAA)

Area Agencies on Aging (AAAs) provide a variety of services to older adults including referrals to in-home and community-based services, housing, home-delivered meals, respite care, Medicare/Medi-Cal counseling, tax assistance, transportation, telephone reassurance, case management, adult day care, legal assistance, and other long-term care services.

L.A. County Community and Senior Services

CALL: 1-800-510-2020
WRITE: 3175 West 6th Street
Los Angeles, CA 90020
EMAIL: Info@CSS.lacounty.gov
WEBSITE: <http://css.lacounty.gov>

The City of Los Angeles Department of Aging has its own AAA for residents living within Los Angeles city ZIP codes.

CALL: 1-213-482-7252 or 1-800-510-2020
FAX: 1-213-482-7256
WRITE: 221 N. Figueroa St., Ste. 500
Los Angeles, CA 90012
EMAIL: age.webinfo@lacity.org
WEBSITE: www.aging.lacity.org



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.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 Manager, 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*.

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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.

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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 managed long-term services and supports (MLTSS).

Our plan will coordinate health care services, behavioral health services, and MLTSS 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, your network PCP **or** our plan must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. 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 PCPs and specialists created to provide coordinated health care services.
 - 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. Authorizations for

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non-emergency services must be obtained from L.A. Care Medicare Plus before seeking that care. In this situation, we cover the care at no cost to you.

- We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. The cost sharing you pay for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost sharing for the dialysis may be higher.
- When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your Care Manager 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 L.A. Care Medicare Plus: In most instances you will be enrolled in L.A. Care Medicare Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in L.A. Care Medicare Plus. 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 L.A. Care Medicare Plus. There will be no gap in your Medi-Cal coverage. Please call us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays if you have any questions.

C. Your Care Manager

C1. What a Care Manager is

A Care Manager is a health professional who will get to know you and understand your health needs. This person might be with your medical group or with L.A. Care Health Plan. Your Care Manager works in a team with you, your doctor(s), caregivers, and others involved in your health care.

Your Care Manager works with you to:

- Assess your health care needs
- Plan your care with you and your Care Team

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- Create your Individual Care Plan that focuses on your needs and your choice
- Coordinate your services
- Communicate with you and your providers
- Follow to see how you are doing and make changes if needed

C2. How you can contact your Care Manager

Contact Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

C3. How you can change your Care Manager

Contact Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

D. Care from providers

D1. Care from a primary care provider

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

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

When you become a member of our plan, you must choose a network provider to be your PCP. Your PCP may be an internist, family practitioner, general practitioner, or OB-GYN doctor who meets State requirements and is trained to give you a basic medical care. You will get your routine or basic care from your PCP. You can also choose a Federally Qualified Health Center (FQHC) as your PCP. FQHCs are health centers that are located in areas that do not have many health care service providers.

Your PCP will coordinate the rest of the covered services you get as a member of our plan. For example, to see a specialist, you may need to get referred to a specialist by your PCP first (this is called getting a "referral" to a specialist). Examples of specialty services that require a referral include:

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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



A Federally Qualified Health Center (FQHC) is a clinic and can be your PCP. FQHCs get money from the federal government because they are located in areas without many health care services. Call L.A. Care Medicare Plus for the names and addresses of the FQHCs that work with L.A. Care Medicare Plus or look in the provider directory.

- “Coordinating” your services include consulting with other plan providers about your care. If you need certain types of covered services or supplies, you must first get approval from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP’s office.

Your choice of PCP

L.A. Care Medicare Plus works with a large number of doctors, specialists, pharmacies, hospitals, and other health care providers. Some of these providers work within a network, sometimes called a “medical group” or an “independent practice association (IPA).” These providers may also be directly contracted with L.A. Care Medicare Plus.

Your primary care provider (PCP) will refer you to specialists and services that are connected with his or her medical group, IPA or with L.A. Care Medicare Plus. If you are going to a specialist already, talk with your PCP or call Member Services at 1-833-522-3767 (TTY 711). Member Services will help you see that provider if you are eligible for continuity of care.

As an L.A. Care Medicare Plus member, you will be enrolled with L.A. Care for both your Medicare and Medi-Cal Programs. You will be assigned a Medicare PCP as your primary doctor who will coordinate both your Medicare and Medi-Cal services, you will not be assigned a Medi-Cal primary doctor. You may change your PCP at any time.

First, you will need to choose a PCP. You may be able to have a specialist act as your PCP. A specialist is a doctor who provides health care services for a specific disease or part of the body. You may choose a specialist as your PCP if that doctor is listed as a PCP in the provider directory. You can get services from any provider who is in our network and accepting new members.

- Choose a PCP that you use now, or
 - who has been recommended by someone you trust, or
 - whose offices are easy for you to get to.
 - If you want help in choosing a PCP, please call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. Or, visit medicare.lacare.org/.

If you have questions about whether we will pay for any medical service or care that you want or need, call Member Services to ask before you get the service or care.

If there is a particular specialist or hospital that you want to use, find out if they’re affiliated with your PCP’s medical group. You can look in the *Provider and Pharmacy Directory*, or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.

Call Member Services to change your PCP. If you notify Member Services of your request for a PCP change before the last business day of the month, the change will be effective the first day of the following month. Member Services will verify that the PCP you choose is accepting new patients. Member Services 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. Member Services will send you a new membership card that shows the name and phone number of your new PCP.

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 Member Services 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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.

Your provider may give you a referral to see a network specialist or certain other providers when it is medically necessary for you to maintain good health. For some types of referrals, your provider may need to get approval in advance from your medical group or from L.A. Care Medicare Plus. This is called getting a "prior authorization".

It is very important to get a prior authorization before you see a network specialist or certain other providers. There are a few exceptions, including routine women's health care that we explained in the section above.

If you don't have a prior authorization before you get services from a specialist or certain other providers, you may have to pay for these services yourself.

If the specialist or certain other provider wants you to come back for more care, check first to be sure that the prior authorization you got for the first visit covers more visits.

If there are specific specialists you want to use, find out whether your provider sends patients to these specialists. Please read Chapter 4, for information about which services require prior authorization.

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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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. Call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free.

D4. Out-of-network providers

When a specific medical service is determined to be medically necessary to ensure continuity of care and the specific medical service is not available from a network health care provider, L.A. Care Medicare Plus or the member's medical group will identify the appropriate out-of-network provider who can provide the medical service. L.A. Care Medicare Plus Plan's or the medical group will execute a special contract with the identified out-of-network provider.

You must get pre-approval (prior authorization) before you go to an out-of-network provider inside the L.A. Care Medicare Plus service area except for emergency care and urgently needed services. If you don't have a prior authorization before you get services from a specialist or certain other providers, you may have to pay for these services yourself.

If you are new to L.A. Care and are in an active service treatment plan or are receiving services from a provider who is not in L.A. Care Medicare Plus Plan's network, L.A. Care Medicare Plus or the medical group will execute a special contract with the identified out-of-network provider. Certain limitations apply. Call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

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

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare. Our plan does not provide Medi-Cal covered behavioral health services, but these services are available to you through Los Angeles County Department of Mental Health or the Los Angeles County Department of Public Health for Substance Abuse, Prevention and Control.

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

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

- Mental health services
- Medication support services

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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 Public Health for Substance Abuse, Prevention and Control, if you meet criteria to receive these services. Drug Medi-Cal services provided by the Los Angeles County Department of Public Health for Substance Abuse, Prevention and Control 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

If you meet medical necessity criteria for specialty mental health services with Los Angeles County DMH and/or for Drug Medi-Cal services with Los Angeles County DPH/SAPC, L.A. Care Medicare Plus will link and coordinate your care with the respective agency. To contact DPH/SAPC directly call 1-844-804-7500, 24 hours a day, seven days a week. L.A. Care Medicare Plus will continue to ensure integration of care planning between your primary care and behavioral health providers.

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 talk to your PCP or other provider and ask for it. Your PCP or other provider will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they will prescribe it by completing a form and submitting it to L.A. Care Medicare Plus for approval. Depending on your medical need, the approval is good for one year. Your PCP or other provider will reassess your need for non-emergency medical transportation for re-approval every 12 months.

Non-emergency medical transportation is an ambulance, litter van, wheelchair van, or air transport. L.A. Care Medicare Plus 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, L.A. Care Medicare Plus will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your PCP or 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.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays at least two business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

Medical transportation limits

L.A. Care Medicare Plus 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, L.A. Care Medicare Plus will help you schedule your transportation. A list of covered services is in Chapter 4 of this handbook. Transportation is not covered outside L.A. Care Medicare Plus's network or service area unless pre-authorized.

F2. 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.

L.A. Care Medicare Plus 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. L.A. Care Medicare Plus 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. L.A. Care Medicare Plus 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. **You cannot be reimbursed for driving yourself.**

Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays at least two business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

Non-medical transportation limits

L.A. Care Medicare Plus 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 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, from any provider with an appropriate state license.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- **As soon as possible, tell our plan about your emergency.** We will follow up on your emergency care. You, your Care Manager or someone 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 L.A. Care Medicare Plus Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

Covered services in a medical emergency

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*.

Medicare does not provide coverage for emergency medical care outside of the United States and its territories. L.A. Care Medicare Plus offers world-wide emergency coverage anywhere in the world. We will cover up to \$10,000 in emergency / urgent costs. To learn more, see the Benefits Chart in Chapter 4.

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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.

How to get urgent care

- Call your PCP. You may speak to an operator who answers calls for your PCP's office when closed.
- Ask to speak to your PCP or the doctor on call. Another doctor may answer your call if your PCP is not available. A doctor is available by phone 24 hours a day, 7 days a week, including holidays.
- Tell them about your condition and follow their instructions.
- Call the Nurse Advice Line at 1-800-249-3619 (TTY: 711), 24 hours a day, 7 days a week, including holidays to help you find an urgent care center near you.

You may receive same-day urgent care services. It should not take longer than 48 hours from the time you call to request an appointment to get urgent care services from your PCP. If you are outside of Los Angeles County, you do not need to call your PCP or get prior authorization before getting urgent care services. Be sure to let your PCP know about this care. You may need follow-up care from your PCP.

Following are the appointment standards for getting other types of appointments:

- Primary Care Physician (PCP) routine appointment within 10 business days
- PCP routine physical examinations within 30 calendar days.
- Specialist Care Physician (SCP) urgent appointments requiring prior authorization within 96 hours.
- SCP routine appointment within 15 business days.

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.

L.A. Care Medicare Plus offers world-wide urgent coverage anywhere outside the United States. We will cover up to \$10,000 in combined emergency/urgent costs. To learn more, see the Benefits Chart in Chapter 4.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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: medicare.lacare.org/.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at the in-network cost-sharing rate. 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 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 Member Services 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 Member Services to find out what the benefit limits are and how much of your benefits you've used.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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

I1. Definition of a clinical research study

L.A. Care Medicare Plus 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. Medi-Cal Rx, a Medi-Cal FFS program, covers most outpatient prescription drugs.

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.

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 Manager should contact Member Services 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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

'Moral Objection'

Some providers have a moral objection to some covered services. This means they have a right not to offer some covered services if they morally disagree with the services. If your provider has a moral objection, they will help you find another provider for the needed services. L.A. Care can also work with you to find a provider.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need:

- Family planning
- Contraception services, including emergency contraception
- Sterilization, including tubal ligation at the time of labor and delivery
- Infertility treatments
- Abortion

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."



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- “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.

For inpatient hospital stays, Medicare coverage limits do not apply if the hospital is in the health plan's network. For more information, see the Benefits Chart in Chapter 4.

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

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

If your DME is not covered by Medicare, it may be covered by Medi-Cal if it is medically necessary. Call Member Services to learn more about Medi-Cal covered DME.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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 L.A. Care Medicare Plus: In most instances you will be enrolled in L.A. Care Medicare Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in L.A. Care Medicare Plus. 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 L.A. Care Medicare Plus. There will be no gap in your Medi-Cal coverage. Please call us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays if you have any questions.

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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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



If you need help understanding what services are covered, call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

A1. During public health emergencies

As a L.A. Care Medicare Plus member, you will have access to your benefits during a public health emergency or a disaster. When one of these events is declared, and until the event ends, L.A. Care Medicare Plus will:

- Cover out-of-network services and benefits at the rate those services and benefits would be provided by network providers
- Waive referral requirements, where applicable
- Make changes that benefit you right away, without the required 30-day notice

L.A. Care Medicare Plus can explain your payment terms and conditions if you live in a disaster area and get care from an out-of-network provider during a declared emergency or disaster.

Call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays for more information.

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 Member Services.

C. About our plan's Benefits Chart

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

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

- 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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 with an asterisk (*).
- If you are within our plan's 3-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, We will not continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period.
- **Important Benefit Information for Members with Certain Chronic Conditions.** If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
 - Chronic alcohol and other drug dependence
 - Autoimmune disorders
 - Cancer
 - Cardiovascular disorders
 - Chronic heart failure
 - Dementia
 - Diabetes
 - End-stage liver disease
 - End-stage renal disease (ESRD)
 - Severe hematologic disorders



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- HIV/AIDS
- Chronic lung disorders
- Chronic and disabling mental health conditions
- Neurologic disorders
- Stroke

You are eligible based on qualifying clinical criteria of a chronic condition as determined and confirmed by your physician. In some cases, you must also participate in one of the plan's Case Management Programs and activities with defined goals and outcome measures.

Our plan offers the following SSBCI benefit:

- Healthy Foods and Grocery
- Home Utility/Gas

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

- All preventive services are free. You find this apple 🍏 next to preventive services in the Benefits Chart.



^Based on your Medi-Cal Eligibility

D. Our plan’s Benefits Chart

Services that our plan pays for	What you must pay
 <p>Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>\$0</p>
<p>Acupuncture We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary. We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; and • not associated with pregnancy. <p>In addition, we 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. Acupuncture treatments for chronic low back pain must be stopped if you don’t get better or if you get worse.</p>	<p>\$0</p>



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

^Based on your Medi-Cal Eligibility

Services that our plan pays for	What you must pay
<p>Acupuncture, Chiropractic and Therapeutic Massage (Non-Medicare covered)</p> <p>Our plan covers up to 45 combined visits every year for Non-Medicare and Medi-Cal covered Acupuncture, Routine Chiropractic and Therapeutic Massage services. In most cases, you must use a contracted provider to receive covered services. Please contact our plan if you have questions on how to use this benefit.</p> <p>Covered Acupuncture services include:</p> <ul style="list-style-type: none"> • Evaluation and Examination • Acupressure • Modalities and therapeutic treatment for pain syndromes • Musculoskeletal conditions • Nausea <p>Covered Chiropractic services include:</p> <ul style="list-style-type: none"> • Evaluation and Examination • X-ray examination • Chiropractic manipulative therapy, modalities and therapeutic procedures • Physical rehabilitation for musculoskeletal conditions of the spine and extremities with clinic-based and telehealth options <p>Covered Therapeutic Massage services include:</p> <ul style="list-style-type: none"> • Clinic-based therapeutic massage services including assessment and therapeutic massage services for treatment of myofascial conditions and injuries and musculoskeletal pain syndromes. 	<p>\$0</p>
<p>Alcohol misuse screening and counseling</p> <p>We pay for one alcohol-misuse screening (SABIRT) and counseling (AMSC) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p>	<p>\$0</p>

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



^Based on your Medi-Cal Eligibility

Services that our plan pays for	What you must pay
<p>Ambulance services*</p> <p>Covered ambulance services include ground, fixed-wing (such as airplances), and rotary-wing (helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.</p> <p>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Annual Physical Exam</p> <p>We pay for one annual physical exam every year. An annual physical exam includes a detailed medical/family history and the a detailed head to toe assessment with hands-on examination.</p>	<p>\$0</p>
<p> Annual wellness visit</p> <p>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.</p>	<p>\$0</p>
<p>Asthma Preventive Services</p> <p>You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.</p>	<p>\$0</p>
<p> Bone mass measurement</p> <p>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.</p> <p>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.</p>	<p>\$0</p>

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



^Based on your Medi-Cal Eligibility

Services that our plan pays for	What you must pay
 <p>Breast cancer screening (mammograms) We pay for the following services:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>\$0</p>
<p>Cardiac (heart) rehabilitation services* We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s referral or order. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
 <p>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)* We pay for one visit a year, or more if medically necessary, with your primary care provider to help lower your risk for heart disease. During the visit, your doctor may:</p> <ul style="list-style-type: none"> • Discuss aspirin use, • Check your blood pressure, and/or • Give you tips to make sure you are eating well. <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
 <p>Cardiovascular (heart) disease testing* We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease. You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



^Based on your Medi-Cal Eligibility

Services that our plan pays for	What you must pay
 <p>Cervical and vaginal cancer screening We pay for the following services:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months • For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years 	<p>\$0</p>
<p>Chiropractic services* We pay for the following services:</p> <ul style="list-style-type: none"> • Adjustments of the spine to correct alignment <p>Note: You will pay all costs for any other services or tests ordered by a chiropractor (including X-rays and massage therapy).</p> <p>See Section: Acupuncture, Chiropractic and Therapeutic Massage (Non-Medicare covered) for additional benefits.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
 <p>Colorectal cancer screening For people 50 and older, we pay for the following services:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years • Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) • Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months. 	<p>\$0</p>



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

^Based on your Medi-Cal Eligibility

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

^Based on your Medi-Cal Eligibility

Services that our plan pays for	What you must pay
<p>Dental services</p> <p>Certain dental services, including but not limited to, cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program or FFS Medi-Cal.</p> <p>L.A. Care Medicare Plus members are entitled to Dental Benefits from Medi-Cal Dental. Those services include such things as dental exams, cleaning, periodontics, laboratory processed crowns, root canals in back teeth, and partial dentures with adjustments, repairs, and relines.</p> <p>Medi-Cal Dental will provide up to \$1,800 in covered services per year and possibly more if medically necessary or if you are residing in a nursing facility. For questions about your coverage or help finding a Medi-Cal Dentist in your area call 1-800-322-6384 or TTY:1-800-735-2922 or visit www.denti-cal.ca.gov.</p>	<p>\$0</p>
<p> Depression screening</p> <p>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.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p>Diabetes screening</p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p> <p>Members with diabetes are eligible to participate in the L.A. Cares About Diabetes® program. This program is available at no cost to members to assist them with the self-management of their diabetes.</p> <p>Members will:</p> <ul style="list-style-type: none"> • receive diabetes information • get instructions on how to create a wellness portal account to access additional resources and self-paced workshops • be able to enroll in the Diabetes Self-Management Education Program (DSME) for individualized in-person or virtual diabetes education 	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Diabetic self-management training, services, and supplies*</p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> ◦ A blood glucose monitor ◦ Blood glucose test strips ◦ Lancet devices and lancets ◦ Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we pay for the following: <ul style="list-style-type: none"> ◦ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, or ◦ One pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) • In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. <p>Members with Diabetes are eligible for the L.A. Cares About Diabetes® program. This is a free program to help members control their diabetes, including:</p> <ul style="list-style-type: none"> – Diabetes health materials – Diabetes classes for you and your family – Nurses to: <ul style="list-style-type: none"> • Coach you to learn how to control blood sugar levels • Review your diabetes medicines • Guide you on healthy eating • Give tips for talking with your doctor about diabetes 	<p>Diabetic self-management training:</p> <p>\$0</p> <p>Diabetic Services and Supplies: ^ You pay \$0 copay or 20% coinsurance for each Medicare covered service or supplies.</p>



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Services that our plan pays for	What you must pay
<p>Doula Services</p> <p>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.</p>	<p>\$0</p>
<p>Durable medical equipment (DME) and related supplies*</p> <p>Refer to the last chapter of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> • Wheelchairs, including electric wheelchairs • Crutches • Powered mattress systems • Dry pressure pad for mattress • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Enteral pump and supplies • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment <p>Other items may be covered.</p> <p>We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.</p> <p style="text-align: center;">This benefit is continued on the next page</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered item.</p>



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Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies* (continued)</p> <p>You should talk to your provider and get a referral for DME items used outside the home.</p>	
<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • Given by a provider trained to give emergency services, and • Needed to treat a medical emergency. <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> • Serious risk to your health or to that of your unborn child; or • Serious harm to bodily functions; or • Serious dysfunction of any bodily organ or part; or • In the case of a pregnant woman in active labor, when: <ul style="list-style-type: none"> ◦ There is not enough time to safely transfer you to another hospital before delivery. ◦ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. <p>Emergency and urgently needed services are covered world-wide without prior authorization. We will cover up to \$10,000 in costs per calendar year. Contact Member Services for additional information.</p>	<p>^ You pay \$0 copay or 20% coinsurance (up to \$95) for each Medicare covered visit.</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.</p>



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



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Services that our plan pays for	What you must pay
<p>Fitness Benefit (SilverSneakers®) L.A. Care Medicare Plus offers a fitness benefit through SilverSneakers®. SilverSneakers® is a fitness benefit that can help improve your health and well-being with regular exercise. SilverSneakers® offers access to locations nationwide where you can use equipment and take group exercise classes. It also provides online and on-demand classes for at-home workouts. Movement and exercise are essential to your health, and SilverSneakers® supports you in any way you decide to move:</p> <p>At home or on the go</p> <ul style="list-style-type: none"> • SilverSneakers On-Demand™ fitness classes available 24/7 • SilverSneakers Live virtual classes and workshops throughout the week • SilverSneakers GO™ mobile app with adjustable workout plans and more • SilverSneakers FLEX® classes, walking groups and workshop at parks, community centers and more <p>In participating fitness locations</p> <ul style="list-style-type: none"> • Thousands of participating locations with various amenities • Ability to enroll at multiple locations at any time • SilverSneakers classes designed for all levels and taught by instructors trained in senior fitness <p>In your community</p> <ul style="list-style-type: none"> • Group activities and classes offered outside the gym • Events including shared meals, holiday celebrations and class socials <p>Get started in 3 easy steps</p> <ol style="list-style-type: none"> 1. Go online to SilverSneakers.com/StartHere to create an online account. 2. Log in to view your member ID number and take that to a participating location. 3. You can also enjoy virtual workouts online through your new account. <p>As a SilverSneakers member, you can save thousands of dollars on tuition for your loved ones, simply by working out at a participating SilverSneakers® location. It's easy and no cost to you. Please visit SilverSneakers.TuitionRewards.com for more information.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Health and wellness education programs</p> <p>We offer many programs that focus on certain health conditions. These include:</p> <ul style="list-style-type: none"> • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; and • Nursing Hotline • Group appointments and wellness workshops in a variety of topics including nutrition, fall prevention, osteoporosis, heart health, senior exercise, caring for a loved one with dementia, asthma, and pre-diabetes. • Individual telephonic counseling with a certified health coach. • Medical Nutrition Therapy with a Registered Dietician (upon PCP referral) • Health education materials in easy-to-read languages and formats, including large print. 	<p>\$0</p>
<p>Hearing services</p> <p>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p> <p>If you are pregnant or reside in a nursing facility, we also pay for hearing aids, including:</p> <ul style="list-style-type: none"> • Molds, supplies, and inserts • Repairs that cost more than \$25 per repair • An initial set of batteries • Six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid • Trial period rental of hearing aids 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Help with certain chronic conditions*</p> <p>Healthy Foods/Grocery & Utility/Gas Flex Card To qualify for the healthy foods and Utility/Gas allowance, you must have one or more of the following conditions and participate in a care management program. You must complete a Health Risk Assessment and your Care Manager will determine if you qualify for this benefit.</p> <ul style="list-style-type: none"> • Chronic alcohol and other drug dependence • Autoimmune disorders • Cancer • Cardiovascular disorders • Chronic heart failure • Dementia • Diabetes • End-stage liver disease • End-stage renal disease (ESRD) • Severe hematologic disorders • HIV/AIDS : Chronic lung disorders • Chronic and disabling mental health conditions • Neurologic disorders • Stroke <p><u>Healthy Foods/Grocery</u> You will receive a prepaid allowance card of \$30 monthly (no roll over) to purchase food and produce through our approved vendor. You can also order by phone, online or have it delivered to your home.</p> <p><u>Utility/Gas Flex Card</u> You will receive a prepaid allowance card of \$30 monthly (no roll over) to pay for home utilities (Electric, Gas, Heating Oil, Sanitary, Water) and gas at the pump through our approved vendor.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p>HIV screening</p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • Ask for an HIV screening test, or • Are at increased risk for HIV infection. <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p> <p>We also pay for additional HIV screening(s) when recommended by your provider.</p>	<p>\$0</p>
<p>Home health agency care*</p> <p>Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>You should talk to your provider and get a referral.</p>	<p>\$0</p>



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<p>Home infusion therapy</p> <p>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:</p> <ul style="list-style-type: none"> • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; and • Supplies, such as tubing or a catheter. <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; and • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Hospice care*</p> <p>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.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare.</p> <ul style="list-style-type: none"> • Refer to Section F of this chapter for more information. <p>For services covered by our plan but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • 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 our plan’s cost-sharing amount for these services. <p>For drugs that may be covered by our plan’s Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to Chapter 5 of your <i>Member Handbook</i>. <p>Note: If you need non-hospice care, call your Care Manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not L.A. Care Medicare Plus.</p> <p>You pay \$0 for the hospice consultation services (one time only).</p>



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Services that our plan pays for	What you must pay
 <p>Immunizations</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to Chapter 6 of your <i>Member Handbook</i> to learn more.</p> <p>We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).</p>	\$0
<p>In-Home Support Services</p> <p>Our plan pays for up to 60 hours per year for In-Home Support Services that includes help with Instrumental Activities of Daily Living. These services include technical guidance, light house help, light exercise and activity, Care Concierge services and assisting members with transportation to include grocery shopping, medication pick-up, and doctor's appointments.</p> <p>Support may be in home or virtual.</p>	\$0

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<p>Inpatient hospital care*</p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.</p> <ul style="list-style-type: none"> • Blood, including storage and administration • Physician services <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



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Services that our plan pays for	What you must pay
<p>Inpatient services in a psychiatric hospital*</p> <p>We pay for mental health care services that require a hospital stay.</p> <ul style="list-style-type: none"> • If you need inpatient services in a freestanding psychiatric hospital, we 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. <ul style="list-style-type: none"> ◦ The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. • If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD). 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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<p>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay*</p> <p>We do not pay for your inpatient stay if it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: <ul style="list-style-type: none"> ◦ An internal body organ (including contiguous tissue), or ◦ The function of an inoperative or malfunctioning internal body organ. • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition • Physical therapy, speech therapy, and occupational therapy 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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<p>Kidney disease services and supplies*</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.</p> <p>You should talk to your provider and get a referral.</p>	<p>Kidney disease education services: \$0</p> <p>Dialysis Services: ^ You pay \$0 copay or 20% coinsurance for each Medicare covered service.</p>



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 <p>Lung cancer screening</p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • Are aged 50-77, and • Have a counseling and shared decision-making visit with your doctor or other qualified provider, and • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p>	<p>\$0</p>
<p>Meal Benefit*</p> <p>This benefit is meant to keep you healthy and strong after an Inpatient Hospital or Skilled Nursing Facility (SNF) stay, or for a medical condition or potential medical condition that requires you to remain at home for a period of time. Your Care Manager or your doctor will decide if you are in need of this benefit.</p> <p>This benefit provides 2 meals a day for up to 14 days with a total of 28 meals delivered, following discharge.</p> <p>You should talk to your provider and get a referral.</p>	<p>\$0</p>
 <p>Medical nutrition therapy</p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred or ordered by your doctor.</p> <p>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.</p> <p>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 or order. A doctor must prescribe these services and renew the referral or order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p>	<p>\$0</p>



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 <p>Medicare Diabetes Prevention Program (MDPP) Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • Long-term dietary change, and • Increased physical activity, and • Ways to maintain weight loss and a healthy lifestyle. 	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs*</p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> • Drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. 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 • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • IV immune globulin for the home treatment of primary immune deficiency diseases <p>The following link takes you to a list of Part B drugs that may be subject to step therapy: medicare.lacare.org.</p> <p>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.</p> <p>Chapter 5 of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <ul style="list-style-type: none"> • Chapter 6 of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan. 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered service.</p>



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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Services that our plan pays for	What you must pay
<p>Nursing facility care*</p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Respiratory therapy • Drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • Blood, including storage and administration • Medical and surgical supplies usually given by nursing facilities • Lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • Use of appliances, such as wheelchairs usually given by nursing facilities • Physician/practitioner services • Durable medical equipment • Dental services, including dentures • Vision benefits <p style="text-align: right;">This benefit is continued on the next page</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Nursing facility care* (continued)</p> <ul style="list-style-type: none"> • Hearing exams • Chiropractic care • Podiatry services <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • A nursing facility where your spouse or domestic partner is living at the time you leave the hospital. <p>You should talk to your provider and get a referral.</p>	
<p> Obesity screening and therapy to keep weight down</p> <p>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.</p>	\$0
<p>Opioid treatment program (OTP) services*</p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>

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Services that our plan pays for	What you must pay
<p>Outpatient diagnostic tests and therapeutic services and supplies*</p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration • Other outpatient diagnostic tests <p>Prior authorization and referral are required, except for diagnostic procedures and services related to COVID-19.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Outpatient hospital services*</p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> ◦ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.” ◦ Sometimes you can be in the hospital overnight and still be “outpatient.” ◦ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/media/11101 • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can’t give yourself <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Outpatient mental health care*</p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental health care professional as allowed under applicable state laws <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services • Day treatment – when you meet the medically necessary criteria for specialty mental health services • Psychosocial rehab services – when you meet the medically necessary criteria for specialty mental health services • Partial hospitalization or Intensive outpatient programs • Individual and group mental health evaluation and treatment • Psychological testing when clinically indicated to evaluate a mental health outcome • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation <p>Visits with a mental health professional by using a phone, electronic tablet or computer in place of going into the clinic or office</p> <p>You should talk to your provider and get a referral</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Outpatient rehabilitation services*</p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p> <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Outpatient substance abuse services*</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician • Subacute detoxification in a residential addiction program • Alcohol and/or drug services in an intensive outpatient treatment center • Extended release Naltrexone (vivitrol) treatment 	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Outpatient surgery*</p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Over-the-Counter (OTC)</p> <p>We will provide up to \$150 quarterly (every 3 months) to use for approved, non-prescription OTC items. Any remaining balance does not rollover to the next quarter. You can use this benefit to order non-prescription OTC health and wellness items such as cough and cold medicine, vitamins, pain relievers and bandages.</p> <p>Your OTC allowance card, along with activation instructions and an OTC catalog will be mailed to you.</p> <p>Getting your items is easy! You can use your OTC allowance card to buy approved, non-prescription OTC items in-store at participating pharmacies and retail locations, online or by phone.</p> <ul style="list-style-type: none"> • In-Store: You can shop for a variety of approved items at Walmart or other participating retailers. Go to lacare.nationsbenefits.com to find a participating store near you. • Online: Go to lacare.nationsbenefits.com to view a variety of approved products. After browsing, you will be automatically transferred to Walmart.com to build your basket and complete your purchase. • By Phone: Review the OTC Catalog or go to lacare.nationsbenefits.com to find the products you want to order. Call 1-833-571-7587, TTY 711 and have the product name(s) and item ID(s) handy. <p>Having the MyBenefits app on your mobile phone helps a lot! You can view your account balance and transactions through the app. You can also check if a product is approved while you're shopping in-store. Download the free app in the App Store® or Google Play™.</p> <p>For additional information, please refer to the 2023 OTC Catalog. If you have any questions, please call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Partial hospitalization services*</p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Personal Emergency Response System (PERS)*</p> <p>Coverage for one Personal Emergency Medical Response Device. An Emergency Medical Response Device is an emergency device that gives you an easy way to call for help at any time. Your Care Manager will decide if you are in need of this benefit.</p>	<p>\$0</p>
<p>Physician/provider services, including doctor's office visits</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> ◦ Physician's office ◦ Certified ambulatory surgical center ◦ Hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider or specialist, if your doctor orders them to find out whether you need treatment <p style="text-align: center;">This benefit is continued on the next page</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> ◦ Certain telehealth services, including those for colds, flu, cough, sinus and chest infections, allergies, skin, fevers, sore throat and ear infections. 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. ◦ Your PCP or PCP’s medical group may offer telehealth services. You should talk to your provider to verify if they offer telehealth services. ◦ Telephonic Consultations: Teladoc will provide members with unlimited toll-free access to telephone consultation by state licensed physicians by calling 1-800-835-2362 (TTY: 711) 24 hours a day, 7 days a week. ◦ Video Consultations: Teladoc will provide members access to private and secure video consultations provided by a physician who is licensed in the state where the member is located 7 a.m. to 9 p.m. / 7 days a week. (Video consultations are available by downloading the Teladoc app to your mobile device. Get the app by going to https://www.teladoc.com/mobile/. • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for members with a substance use disorder or co-occurring mental health disorder <p style="text-align: center;">This benefit is continued on the next page</p>	



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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers. • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if <ul style="list-style-type: none"> ◦ You’re not a new patient and ◦ The check-in isn’t related to an office visit in the past 7 days and ◦ The check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if <ul style="list-style-type: none"> ◦ You’re not a new patient and ◦ The evaluation isn’t related to an office visit in the past 7 days and ◦ The evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient • Second opinion by another network provider before surgery <p style="text-align: center;">This benefit is continued on the next page</p>	



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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> ◦ Surgery of the jaw or related structures ◦ Setting fractures of the jaw or facial bones ◦ Pulling teeth before radiation treatments of neoplastic cancer ◦ Services that would be covered when provided by a physician 	
<p>Podiatry services*</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Routine Podiatry Services</p> <p>Our plan covers up to 12 routine foot care visits every year for Non-Medicare and Medi-Cal covered Podiatry.</p> <p>Routine foot care can include:</p> <ul style="list-style-type: none"> • Cutting or removing corns and calluses • Trimming, cutting, or clipping nails • Hygienic or other preventive maintenance, like cleaning and soaking your feet 	<p>\$0</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Prosthetic devices and related supplies*</p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Prostheses to replace all of part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect • Incontinence cream and diapers <p>We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Pulmonary rehabilitation services*</p> <p>We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have a referral or an order for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p>We pay for respiratory services for ventilator-dependent patients. You should talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p>Sexually transmitted infections (STIs) screening and counseling</p> <p>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.</p> <p>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.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Skilled nursing facility (SNF) care*</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Supervised exercise therapy (SET)*</p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD).</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"> • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider <p>The SET program must be:</p> <ul style="list-style-type: none"> • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician’s office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques <p>You should talk to your provider and get a referral.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>
<p>Transportation: Non-emergency medical transportation*</p> <p>This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.</p> <p>The forms of transportation are authorized when:</p> <ul style="list-style-type: none"> • Your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, and <p>Depending on the service, prior authorization may be required.</p> <p>L.A. Care works with your doctor to help you schedule the transportation you need to get to and from your L.A. Care Medicare Plus covered services. Scheduling may require a provider’s request and L.A. Care approval. Call L.A. Care Medicare Plus Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays, to learn more about your transportation options and how to schedule a ride.</p>	<p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Transportation: Non-medical transportation</p> <p>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.</p> <p>Transportation is required for the purpose of obtaining needed medical care, including travel to doctor appointments and to pick up prescription drugs.</p> <p>This benefit does not limit your non-emergency medical transportation benefit.</p> <p>L.A. Care can help you schedule the transportation you need to get to and from your services that are covered by L.A. Care Medicare Plus. Call L.A. Care Medicare Plus Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays, to learn more about your transportation options and how to schedule a ride.</p>	<p>\$0</p>
<p>Urgent care</p> <p>Urgent care is care given to treat:</p> <ul style="list-style-type: none"> • A non-emergency that requires immediate medical care, or • A sudden medical illness, or • An injury, or • A condition that needs care right away. <p>If you require urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p>Emergency and urgently needed services are covered world-wide without prior authorization. We will cover up to \$10,000 in costs per calendar year. Contact Member Services for additional information.</p>	<p>^ You pay \$0 copay or 20% coinsurance (up to \$60) for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
<p>Vision care*</p> <p>Routine Vision Services</p> <p>We pay for routine services when provided through our network of VSP providers. Please visit our provider directory for a doctor near you. Routine benefits include:</p> <ul style="list-style-type: none"> • One routine eye exam every year and • Up to \$500 for eyeglasses (frames and lenses) or up to \$500 for contact lenses every two years. <p>Medicare-covered services*</p> <p>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.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • People with a family history of glaucoma • People with diabetes • African-Americans who are age 50 and older • Hispanic Americans who are 65 or older <p>We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.</p>	<p>Routine Services: \$0</p> <p>^ You pay \$0 copay or 20% coinsurance for each Medicare covered visit.</p>



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Services that our plan pays for	What you must pay
 <p>“Welcome to Medicare” preventive visit</p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> • A review of your health, • Education and counseling about the preventive services you need (including screenings and shots), and • Referrals for other care if you need it. <p>Note: We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.</p>	<p>\$0</p>



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E. Benefits covered outside of our plan

We don't cover the following services, but they are available through Original Medicare or MediCal 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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 pay for them either.

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

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

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

- Services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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.
- Regular hearing exams, hearing aids, or exams to fit hearing aids.
- 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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-order. They include drugs covered under Medicare Part D and Medi-Cal. Key terms and their definitions appear in alphabetical order in the last chapter of 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 or any similar Medicaid lists, State Medicaid Exclusion List and State Sanctioned or any similar State Medicaid lists.
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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

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

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

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 Member Services right away.** We will do everything we can to help.

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

A3. What to do if you change your network pharmacy

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

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

A4. What to do if your pharmacy leaves the network

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

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Member Services.
- 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 Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

Our plan's mail-order service allows you to order at least a 30-day supply of the drug and no more than a 100-day supply. A 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, please visit our website at medicare.lacare.org/ or contact Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays, for more information.

Usually, a mail-order prescription arrives within 14 days.

However, sometimes your mail-order may be delayed. You must contact your doctor to request a short-term prescription to cover the period until the mail-order medication arrives.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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-order prescriptions

For refills, contact your pharmacy 21 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 call L.A. Care Medicare Plus Member Services to let us know the best way to reach you.

A7. Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 100-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

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

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

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

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

- If the covered Part D drug is related to care for a medical emergency.
- If a particular covered Part D drug (for example, an orphan drug or other specialty pharmaceutical typically shipped directly from manufacturers or special vendors) is not regularly stocked at accessible network retail or mail-order pharmacies.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- If a covered Part D drug is dispensed by an institution-based pharmacy while he or she is a patient in an emergency department, provider-based clinic, outpatient surgery, or other outpatient setting.
- During any Federal disaster or other public health emergency in which an enrollee is evacuated or otherwise displaced from their place of residence.
- In emergency situations in which an enrollee is not able to use a network pharmacy, we will pay for a one-time 30-day supply for generic drugs. For brand drugs, we will pay for a one-time 30-day supply. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

In these cases, check with Member Services 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.

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

B2. How to find a drug on our Drug List

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

- Check the most recent Drug List we sent you in the mail.
- Visit our plan’s website at medicare.lacare.org/. The Drug List on our website is always the most current one.
- Call Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (medi-calrx.dhcs.ca.gov/) for more information

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 (5) cost-sharing tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter (OTC) drugs). In general, the higher the cost-sharing tier, the higher your cost for the drug.

- Tier 1 (Lowest Tier): Preferred Generic Drugs
- Tier 2: Generic Drugs
- Tier 3: Preferred Brand Drugs
- Tier 4: Non-Preferred Brand Drugs
- Tier 5: (Highest Tier): Specialty Drugs

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

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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 or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.
- Your copay may be greater for the brand name drug than for the generic drug.

2. Getting plan approval in advance

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

3. Trying a different drug first

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

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

4. Quantity limits

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

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at medicare.lacare.org. 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:



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- 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.
 - You may experience a change in the level of care received and/or may be required to transition (move) from one facility or treatment site to another. Exceptions (special cases) are available to you if you experience a change in the level of care being received. If you experience a change in level of care, L.A. Care Medicare Plus will cover a temporary 30-day supply (unless you have a prescription written for fewer days).
 - To ask for a temporary supply of a drug, call Member Services.

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

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

OR

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

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

If you need help asking for an exception, contact Member Services. 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).



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 medicare.lacare.org/ **or**
- Call Member Services 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. If you get one of these letters, please speak with your doctor to find a different drug that is safe for you.

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**



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 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 Member Services.

F3. In a Medicare-certified hospice program

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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 Member Services.

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 or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from a certain pharmacy and/or from a certain doctor
- Limiting the amount of those medications we 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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 Member Services and ask for the “LIS Rider.”

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

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

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

- *Our List of Covered Drugs.*
 - We call this the “Drug List.” It tells you:
 - Which drugs we pay for
 - Which of the (5) cost-sharing tiers each drug is in
 - If there are any limits on the drugs
 - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at medicare.lacare.org.
 - Most of the prescription drugs you get from a pharmacy are covered by L.A. Care Medicare Plus. 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.”

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- **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.

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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*. The Part D Explanation of Benefits tells you the total amount you, others on your behalf, and we have spent on your Part D prescription drugs and the total amount paid for each of your Part D prescription drugs during each month the Part D benefit is used. 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.

- 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 L.A. Care Medicare Plus 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** of your *Member Handbook*.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, 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 Member Services. Keep these Part D EOBs. They are an important record of your drug expenses.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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
<p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p>	<p>During this stage, we pay all of the costs of your drugs through December 31, 2023.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p>

D. Stage 1: The Initial Coverage Stage

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

Cost-sharing tiers are groups of drugs with the same copay. Every drug on our plan's Drug List is in one of five (5) cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, refer to our Drug List.

- Tier 1 drugs are preferred generic drugs. The copay is \$0.
- Tier 2 drugs are generic drugs. The copay is from \$0 - \$10.35 or \$20. Your copay depends on the amount of Extra Help you receive.
- Tier 3 drugs are preferred brand drugs. The copay is from \$0 - \$10.35 or \$47. Your copay depends on the amount of Extra Help you receive.
- Tier 4 drugs are non-preferred brand drugs. The copay is from \$0 - \$10.35 or \$100. Your copay depends on the amount of Extra Help you receive.
- Tier 5 drugs are specialty drugs. The copay is from \$0 - \$10.35 or 25% coinsurance. Your copay depends on the amount of Extra Help you receive.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).



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 up to a 100-day supply. 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 Member Services to find out how much your copay is for any covered drug.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

	A network pharmacy A one-month or up to a 100-day supply	Our plan's mail-order service A one-month or up to a 100-day supply	A network long-term care pharmacy Up to a 31-day supply	An out-of-network pharmacy Up to a 30-day supply. Coverage is limited to certain cases. Refer to Chapter 5 of your <i>Member Handbook</i> for details.
Cost-sharing Tier 1 (Preferred Generic Drugs)	\$0	\$0	\$0	\$0
Cost-sharing Tier 2 (Generic Drugs)	\$0 - \$10.35 or \$20 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$20 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$20 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$20 Your copay depends on the amount of Extra Help you receive.
Cost-sharing Tier 3 (Preferred Brand Drugs)	\$0 - \$10.35 or \$47 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$47 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$47 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$47 Your copay depends on the amount of Extra Help you receive.
Cost-sharing Tier 4 (Non-Preferred Brand Drugs)	\$0 - \$10.35 or \$100 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$100 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$100 Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or \$100 Your copay depends on the amount of Extra Help you receive.
Cost-sharing Tier 5 (Specialty Drugs)	\$0 - \$10.35 or 25% Coinsurance Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or 25% Coinsurance Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or 25% Coinsurance Your copay depends on the amount of Extra Help you receive.	\$0 - \$10.35 or 25% Coinsurance Your copay depends on the amount of Extra Help you receive.

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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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, even if you haven't paid your deductible.

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:

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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

We cover Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

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

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

We recommend that you call Member Services 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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

Important Message About What You Pay for Vaccines - Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible. Call Member Services for more information.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 cost, the bill, it is your right to be paid back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services 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, refer to Chapter 3, Section D4 on page 42.

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you 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 Member Services if you get any bills. Do not pay the bill.**



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- 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 your covered services **or** 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 Manager for help.

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

L.A. Care Medicare Plus
Attn: Appeals & Grievances Department
1055 West 7th Street 10th Floor
Los Angeles, CA 90017

You may also call us to ask for payment. Call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

You must submit your claim to us within 60 days 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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**.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Interpreting services are available. To get an interpreter, just call us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. You can get this information free in Arabic, Armenian, Cambodian (Khmer), Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. To obtain materials in one of these alternative formats, please call or write to:

L.A. Care Medicare Plus
 Attn: Member Services Department
 1055 West 7th Street
 Los Angeles, CA 90017

- If you want to receive materials, including new materials, now and in the future, in a language other than English or in an alternate format, call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free.
- Members have the right to make recommendations regarding the organization's member rights and responsibilities policy.

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 1-916-440-7370. TTY users should call 711.

A. Su derecho de obtener servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que **todos** los servicios se le brinden de una manera culturalmente competente y accesible. También debemos informarle sobre los beneficios de nuestro plan y sus derechos de una manera que pueda comprender. Debemos informarle sobre sus derechos cada año que sea miembro de nuestro plan.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- Para obtener información en una manera que pueda comprender, llame a Servicios para los Miembros. Nuestro plan cuenta a servicios gratuitos de interpretación para responder a las preguntas en diferentes idiomas.
- Los servicios de interpretación están disponibles. Para obtener los servicios de un intérprete, puede llamarnos al 1-833-522-3767 (TTY: 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos.
- Nuestro plan también puede brindarle materiales en otros idiomas además del inglés y en formatos como en letra grande, braille o audio. Puede obtener esta información de forma gratuita en árabe, armenio, camboyano (Khmer), chino, farsi, coreano, ruso, español, tagalog y vietnamita. Para obtener materiales en uno de estos formatos alternativos, llame o escriba a:

L.A. Care Medicare Plus
 Attn: Member Services Department
 1055 West 7th Street
 Los Angeles, CA 90017

- Si desea recibir los materiales, incluyendo los nuevos materiales, ahora y en el futuro, en un idioma que no sea el inglés o en un formato alternativo, llame a Servicios para los Miembros al 1-833-522-3767 (TTY: 711), las 24 horas del día, los 7 días de la semana, incluso los días festivos. La llamada es gratuita.
- Los miembros tienen derecho a hacer recomendaciones con respecto a la política de derechos y responsabilidades de los miembros de la organización.

Si tiene problemas para obtener información de nuestro plan debido a problemas con el idioma o una discapacidad y desea presentar una queja, llame a:

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

A. Ծառայություններ և եղեկություններ ձեզ հարմար ձևով ստանալու ձեր իրավունքը

Մենք պետք է երաշխավորենք, որ **բոլոր** ծառայությունները ձեզ տրամադրվում են մշակութային ձեռնհասությամբ և մատչելի կերպով: Մենք պետք է նաև տեղեկացնենք ձեզ մեր ծրագրի նպաստների և ձեր իրավունքների մասին ձեզ հարմար հասկանալի ձևով: Մենք պետք է տեղեկացնենք ձեզ ձեր իրավունքների մասին յուրաքանչյուր տարի, որ դուք ծրագրի անդամ եք:

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- Ձեզ համար հասկանալի ձևով տեղեկություններ ստանալու համար զանգահարեք Անդամների սպասարկման բաժին: Մեր ծրագիրն ունի բանավոր թարգմանչական ծառայություններ, որոնք կարող են պատասխանել ձեր հարցերին տարբեր լեզուներով:
- Մատչելի են բանավոր թարգմանչական ծառայություններ: Բանավոր թարգմանիչ ստանալու համար պարզապես զանգահարեք մեզ 1-833-522-3767 հեռախոսահամարով (TTY՝ 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոն օրերը:
- Մեր ծրագիրը կարող է ձեզ նյութեր տրամադրել անգլերենից բացի այլ լեզուներով և այլ ձևաչափերով, օրինակ՝ խոշոր տառատեսակով, Բրեյլի լեզվով կամ ձայնագրությամբ: Այս տեղեկությունները կարող եք անվճար ստանալ արաբերենով, հայերենով, կամբոջերենով (քմեր), չինարենով, պարսկերենով, կորեերենով, ռուսերենով, իսպաներենով, տագալոգերենով և վիետնամերենով: Այս այլընտրանքային ձևաչափերից մեկով նյութեր ստանալու համար խնդրում ենք զանգահարել կամ գրել այստեղ՝

L.A. Care Medicare Plus
Attn: Member Services Department
1055 West 7th Street
Los Angeles, CA 90017

- Եթե այժմ և ապագայում ցանկանում եք ստանալ նյութերը, ներառյալ նոր նյութերը, անգլերենից բացի մեկ այլ լեզվով կամ այլընտրանքային ձևաչափով, զանգահարեք Անդամների սպասարկման բաժին՝ 1-833-522-3767 հեռախոսահամարով (TTY՝ 711), օրը 24 ժամ, շաբաթը 7 օր, ներառյալ տոն օրերը: Զանգն անվճար է:
- Անդամներն իրավունք ունեն առաջարկություններ անել կազմակերպության անդամի իրավունքների և պարտականությունների քաղաքականության վերաբերյալ:

Եթե մեր ծրագրից տեղեկություններ ստանալու հետ կապված դժվարություններ ունեք՝ լեզվի հետ կապված խնդիրների կամ հաշմանդամության պատճառով, և ցանկանում եք բողոք ներկայացնել, զանգահարեք՝

- Medicare՝ 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով: Դուք կարող եք զանգահարել օրը 24 ժամ, շաբաթը 7 օր: TTY օգտագործողները պետք է զանգահարեն 1-877-486-2048 հեռախոսահամարով:
- ԱՄՆ Առողջապահության և մարդու ծառայությունների բաժնի Քաղաքացիական իրավունքների գրասենյակ՝ 1-800-368-1019 հեռախոսահամարով: TTY օգտագործողները պետք է զանգահարեն 1-800-537-7697 հեռախոսահամարով:
- Medi-Cal-ի Քաղաքացիական իրավունքների գրասենյակ՝ 1-916-440-7370 հեռախոսահամարով: TTY օգտագործողները պետք է զանգահարեն 711 հեռախոսահամարով:



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

A. សិទ្ធិរបស់អ្នកក្នុងការទទួលបានសេវាកម្ម និងព័ត៌មានស្របតាមសម្រូវការ

យើងត្រូវធានាថាគ្រប់ សេវាកម្មដែលផ្តល់ដោយអ្នកគឺស្របតាមវប្បធម៌ និងក្នុងឥរិយាបថដែលអ្នកអាចទាក់ទងបាន។ យើងក៏ត្រូវប្រាប់អ្នកអំពីអត្ថប្រយោជន៍គម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកទៅតាមមធ្យោបាយដែលអ្នកអាចយល់បាន។ ជាង្រៀងរាល់ឆ្នាំ យើងត្រូវប្រាប់អ្នកពីសិទ្ធិរបស់អ្នកនៅក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មាននេះតាមរបៀបណាមួយដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅកាន់ផ្នែកសេវាសមាជិក។ គម្រោងរបស់យើងមានសេវាកម្មប្រែសម្រួលភាសាផ្សេងៗ។
- សេវាកម្មប្រែមាននៅទីនេះ។ ដើម្បីទទួលបានអ្នកបកប្រែ សូមខលយើងតាមរយៈលេខទូរសព្ទ 1-833-522-3767 (TTY: 711), 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍រួមទាំងថ្ងៃសម្រាក។
- គម្រោងរបស់យើងអាចផ្តល់សម្ភារៈជាភាសាផ្សេងៗក្រៅពីអង់គ្លេស និងជាច្រើនទម្រង់ ដូចជា ព្រីនអក្សរធំ អក្សរសម្រាប់មនុស្សពិការភ្នែក ឬជាសម្លេងជាដើម។ អ្នកអាចទទួលបានព័ត៌មាននេះដោយឥតគិតថ្លៃជាភាសាអារ៉ាប់ អាមេរិកកម្ពុជា (ខ្មែរ) ចិន ហ្វីលីពីន កូរ៉េ រុស្ស៊ី អេស្ប៉ាញ តាហ្គាឡុក និងវៀតណាម។ ដើម្បីទទួលបានសម្ភារៈនៅក្នុងទម្រង់ណាមួយ សូមខលឬសរសេរទៅកាន់៖

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- ប្រសិនបើអ្នកចង់ទទួលបានសម្ភារៈ រួមទាំងសម្ភារៈថ្មី ក្នុងពេលនេះនិងពេលអនាគត ជាភាសាណាមួយក្រៅពីភាសាអង់គ្លេស ឬជាទម្រង់ណាមួយ សូមខលទៅកាន់សេវាកម្មសមាជិកតាមរយៈលេខទូរសព្ទ 1-833-522-3767 (TTY: 711), 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍រួមទាំងថ្ងៃសម្រាក។ ការហៅគឺឥតគិតថ្លៃ
- សមាជិកមានសិទ្ធិក្នុងការផ្តល់ការណែនាំ ទាក់ទងនិងសិទ្ធិសមាជិកនិងគោលការណ៍ទំនួលខុសត្រូវរបស់អង្គការផងដែរ។

ប្រសិនបើអ្នកមានបញ្ហាពិបាកក្នុងការទទួលបានព័ត៌មានពីគម្រោងយើង ពីព្រោះបញ្ហាភាសា ឬភាពអសមត្ថភាព និងចង់ធ្វើការប្តឹងសូមខលទៅកាន់៖

- Medicare at 1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចធ្វើការហៅ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ អ្នកប្រើប្រាស់ TTY គួរតែទូរសព្ទទៅលេខ 1-877-486-2048។
- ក្រសួងសុខាភិបាលនិងសេវាមនុស្សជាតិសហរដ្ឋអាមេរិក ការិយាល័យសិទ្ធិពលរដ្ឋ តាមរយៈលេខ 1-800-368-1019។ អ្នកប្រើ TTY គួរតែហៅទូរសព្ទទៅលេខ 1-800-537-7697។
- ការិយាល័យសិទ្ធិពលរដ្ឋនៃ Medi-Cal 1-916-440-7370។ អ្នកប្រើ TTY គួរតែទូរសព្ទទៅលេខ 711។



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

A. حق شما برای دریافت خدمات و اطلاعات به گونه‌ای که نیازهای شما را برآورده کند

ما باید اطمینان حاصل کنیم که همه خدمات به شیوه فرهنگی مناسب و قابل دسترس به شما ارائه می‌شود. ما باید شما را از حقوق و مزایای طرح ما به شیوه‌ای مطلع سازیم که برای شما قابل درک باشد. ما باید هر سال در صورت عضویت شما در طرح، حقوق‌تان را برای شما بازگو کنیم.

- برای کسب این اطلاعات با خدمات اعضاء تماس بگیرید. طرح ما دارای خدمات مترجم رایگان برای پاسخ به سوالات به زبان‌های مختلف است.
- خدمات مترجم شفاهی موجود است. برای داشتن مترجم شفاهی، فقط کافی است با ما به شماره تلفن 1-833-522-3767 (TTY: 711) به صورت 24 ساعته و 7 روز هفته، از جمله تعطیلات، تماس بگیرید.
- طرح ما می‌تواند مطالب را به زبان‌هایی دیگر غیر از انگلیسی و به صورت‌های دیگر مانند چاپ درشت، بریل یا فایل صوتی برای شما فراهم کند. شما می‌توانید این اطلاعات را به صورت رایگان به زبان‌های عربی، ارمنی، کامبوجی (خمری)، چینی، فارسی، کره‌ای، روسی، اسپانیایی، تاگالوگ و ویتنامی دریافت کنید. برای دریافت منابع در یکی از این قالب‌های جایگزین، لطفاً با شماره زیر تماس بگیرید یا بنویسید:

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- اگر می‌خواهید مطالب و بروشورهای مربوطه، از جمله مطالب جدید را، اکنون یا در آینده، به زبانی غیر از زبان انگلیسی یا به سایر فرمت‌ها دریافت کنید، می‌توانید 24 ساعت شبانه روز، 7 روز هفته، از جمله روزهای تعطیل، با خدمات مشتریان به شماره 1-833-522-3767 (TTY: 711) تماس بگیرید. این تماس رایگان است.
- اعضاء حق دارند در مورد سیاست حقوق و مسئولیت‌های سازمان توصیه‌هایی را ارائه کنند.
- اگر به دلیل مشکلات زبانی یا ناتوانی در دریافت اطلاعات از طرح ما مشکل دارید و می‌خواهید شکایت کنید، تماس بگیرید:
- Medicare به شماره 1-800-MEDICARE (1-800-633-4227) : می‌توانید در 24 ساعت شبانه روز و 7 روز هفته با این شماره‌ها تماس بگیرید. کاربران TTY باید با شماره تلفن 1-877-486-2048 تماس بگیرند.
- با اداره خدمات بهداشتی و انسانی، دفتر حقوق مدنی به شماره 1-800-368-1019 تماس بگیرید. کاربران TTY باید با شماره تلفن 1-800-537-7697 تماس بگیرند.
- دفتر حقوق مدنی Medi-Cal به شماره 1-916-440-7370. کاربران TTY باید با شماره 711 تماس بگیرند.

A. 가입자의 요구 사항에 부합하는 방식으로 서비스와 정보를 얻을 권리

당사는 가입자에게 제공되는 모든 서비스가 문화적으로 능숙하고 접근성이 좋은 방식으로 제공되도록 해야 합니다. 또한 가입자가 이해할 수 있는 방식으로 플랜의 혜택과 가입자의 권리를 알려야 할 의무도 있습니다. 가입자가 플랜에 가입한 이상 매년 가입자의 권리를 알려야 합니다.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 정보를 이해하기 쉬운 방식으로 받으시려면 가입자 서비스부에 연락하십시오. 플랜에서 무료 통역사 서비스를 제공하여 다양한 언어로 질문에 답해드리고 있습니다.
- 무료 통역사 서비스가 제공됩니다. 통역사 서비스를 이용하려면 1-833-522-3767 (TTY: 711) 번으로 전화하기만 하면 됩니다. 이 전화는 하루 24시간, 연중무휴로 운영합니다(공휴일 포함).
- 플랜에서는 영어 외의 다른 언어로 작성된 자료를 대형 활자 인쇄, 점자 또는 오디오와 같은 형식으로 제공하기도 합니다. 이러한 정보는 아랍어, 아르메니아어, 캄보디아어(크메르어), 중국어, 페르시아어, 한국어, 러시아어, 스페인어, 타갈로그어와 베트남어 버전으로 무료 제공됩니다. 이러한 대체 형식으로 자료를 받아보려면 전화 문의하거나 다음 우편 주소로 문의하시기 바랍니다.

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- 지금이든 앞으로든 신규 자료를 포함한 여러 가지 자료를 영어 외의 다른 언어나 대체 형식으로 받아보고자 하는 경우, 가입자 서비스에 1-833-522-3767 (TTY: 711) 번으로 문의하십시오. 이 전화는 하루 24시간, 연중무휴로 운영합니다(공휴일 포함). 통화료는 무료입니다.
- 가입자에게는 당사의 가입자 권리 및 책임 규정에 관해 추천안을 제시할 권리가 있습니다.

언어 문제나 장애로 인해 플랜에서 정보를 얻는 데 어려움을 겪었고 이에 따라 불만을 제기하고자 하는 경우, 다음 전화번호로 문의하십시오.

- Medicare에 1-800-MEDICARE (1-800-633-4227)번으로 문의하십시오. 이 전화는 24시간, 연중무휴 언제든지 이용하셔도 됩니다. TTY 이용자는 1-877-486-2048번으로 전화하십시오.
- 미국 보건 사회복지부 인권국에 1-800-368-1019번으로 문의하십시오. TTY 이용자는 1-800-537-7697번으로 전화하십시오.
- Medi-Cal 인권국 번호는 1-916-440-7370입니다. TTY 이용자는 711번으로 전화하십시오.

A. Ваше право на получение информации в соответствии с вашими потребностями

Мы должны удостовериться, что **все** услуги предоставляются вам культурно компетентным и доступным образом. Мы должны уведомлять вас о льготах в рамках

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плана и о ваших правах так, чтобы было вам понятно. Мы обязаны разъяснять вам ваши права каждый год, в течение которого вы являетесь участником нашего плана.

- Для получения информации наиболее понятным для вас способом позвоните в отдел обслуживания участников плана. Наш план предлагает бесплатные услуги устного переводчика, чтобы отвечать на вопросы на разных языках.
- Услуги устного перевода предоставляются бесплатно. Чтобы воспользоваться услугами устного переводчика, просто позвоните нам по телефону 1-833-522-3767 (линия ТТУ: 711) круглосуточно, ежедневно, включая праздничные дни.
- Наш план также может предоставить вам материалы на других языках и в других форматах, таких как крупный шрифт, шрифт Брайля и аудиозапись. Данные материалы можно получить бесплатно на испанском, армянском, камбоджийском (кхмерском), фарси, корейском, русском, тагальском, традиционном китайском, вьетнамском или арабском языках. Чтобы получить материалы в одном из этих альтернативных форматов, позвоните или напишите по адресу:

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- Если вы хотите сейчас или в будущем получать материалы, включая новые, на вашем языке или в удобном для вас формате, звоните в отдел обслуживания участников по телефону 1-833-522-3767 (линия ТТУ: 711) круглосуточно, ежедневно, включая праздничные дни. Звонок бесплатный.
- У участников есть право вносить рекомендации, касающиеся правил о правах участников организации и их обязанностей.

Если вам трудно получить информацию от нашего плана по причине языкового барьера или инвалидности, и вы хотите подать жалобу, позвоните:

- в программу Medicare: 1-800-MEDICARE (1-800-633-4227) Вы можете звонить круглосуточно и ежедневно. Пользователям линии ТТУ следует звонить по телефону 1-877-486-2048.
- Звоните в Управление по гражданским правам Министерства здравоохранения и социального обеспечения по телефону 1-800-368-1019. Пользователям линии ТТУ следует звонить по телефону: 1-800-537-7697.
- в программу Medi-Cal, Управление по гражданским правам, по телефону 916-440-7370. Пользователям линии ТТУ следует звонить по телефону 711.

A. Ang inyong karapatang makatanggap ng mga serbisyo at impormasyon sa paraan na tumutugon sa mga pangangailangan ninyo

Dapat naming tiyakin na ang **lahat** serbisyo ay ibinibigay sa inyo sa paraan na naiintindihan ang kultura at naa-access. Dapat naming sabihin sa inyo ang tungkol sa mga benepisyo

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ng aming plano at ang inyong mga karapatan sa paraan na maiintindihan ninyo. Dapat naming sabihin sa inyo ang tungkol sa inyong mga karapatan bawat taon na kayo ay nasa aming plano.

- Upang kumuha ng impormasyon sa isang paraan na maiintindihan ninyo, tawagan ang Mga Serbisyo para sa Miyembro. Ang aming plano ay may mga libreng serbisyo ng interpreter na magagamit upang sagutin ang mga tanong sa iba't ibang wika.
- Mayroong mga serbisyo ng pagsasalin-wika. Upang makakuha ng interpreter, tawagan lang kami sa 1-833-522-3767 (TTY: 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kasama ang mga holiday.
- Ang aming plano ay makakapagbigay din sa inyo ng mga materyal sa mga wika bukod sa Ingles at sa mga format tulad ng malaking letra, braille, o audio. Maaari ninyong makuha ang impormasyong ito nang libre sa Arabic, Armenian, Cambodian (Khmer), Chinese, Farsi, Korean, Russian, Espanyol, Tagalog, at Vietnamese. Para makakuha ng mga materyal na nasa isa sa mga alternatibong format na ito, mangyaring tumawag o sumulat sa:

L.A. Care Medicare Plus
Attn: Member Services Department
1055 West 7th Street
Los Angeles, CA 90017

- Kung gusto ninyong makatanggap ng mga materyal, kabilang ang mga bagong materyal, ngayon at sa hinaharap, nang nasa wika bukod sa Ingles o sa alternatibong format, tumawag sa Mga Serbisyo para sa Miyembro sa 1-833-522-3767 (TTY: 711), 24 na oras sa isang araw, 7 araw sa isang linggo, kasama ang mga holiday. Libre ang pagtawag.
- Ang mga miyembro ay may karapatang gumawa ng mga rekomendasyon tungkol sa patakaran sa mga karapatan at responsibilidad ng miyembro ng organisasyon.

Kung nahihirapan kayong makakuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto ninyong magsampa ng reklamo, tumawag sa:

- Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kayong tumawag nang 24 na oras sa isang araw, 7 araw sa isang linggo. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-877-486-2048.
- Departamento ng Mga Serbisyo para sa Kalusugan at Tao ng Estados Unidos, Tanggapan para sa Mga Karapatang Sibil sa 1-800-368-1019. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-800-537-7697.
- Tanggapan ng Medi-Cal para sa Mga Karapatang Sibil sa 1-916-440-7370. Ang mga gumagamit ng TTY ay dapat tumawag sa 711.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

A. 您有權以符合您需求的方式獲得服務和資訊

我們必須確保以符合您文化背景且無障礙的方式為您提供**所有**服務。我們也必須以您能理解的方式告訴您本計劃的福利和您的權利。在您參加我們計劃的期間，我們每年皆必須向您說明您的權利。

- 如要獲得以您能理解的方式提供的資訊，請致電會員服務部。本計劃有免費的口譯服務，可以使用不同語言回答問題。
- 您可使用口譯服務。若需要使用口譯員，您只需致電 1-833-522-3767 (TTY: 711) 與我們聯絡即可，服務時間為每週 7 天，每天 24 小時（包含假日）。
- 本計劃也可以為您提供英文以外之其他語言版本以及像是大字版、盲文版或語音版格式的資料。您可免費取得本資訊的阿拉伯文版、亞美尼亞文版、柬埔寨文版（高棉文版）、中文版、波斯文版、韓文版、俄文版、西班牙文版、塔加拉文版及越南文版。如與取得上述其中一種替代格式的資料，請致電或寫信至：

L.A. Care Medicare Plus
 Attn: Member Services Department
 1055 West 7th Street
 Los Angeles, CA 90017

- 如果您希望立即並在日後取得英文以外之其他語言版本或其他格式的資料（包括新資料），請致電 1-833-522-3767 (TTY: 711) 與會員服務部聯絡，服務時間為每週 7 天，每天 24 小時（包含假日）。上述電話均為免費。
- 會員有權針對組織的會員權利與責任政策提出建議。

如果您因語言或殘障問題在獲取我們計劃提供的資訊方面遇到困難並想提出投訴，請致電：

- Medicare，電話號碼為 1-800-MEDICARE (1-800-633-4227)。您每週 7 天，每天 24 小時均可致電。TTY 使用者請致電 1-877-486-2048。
- 請致電 1-800-368-1019 與美國衛生及公共服務部民權辦公室聯絡。TTY 使用者請致電 1-800-537-7697。
- Medi-Cal 民權辦公室電話 1-916-440-7370。TTY 使用者請致電 711。

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



A. Quý vị có quyền được nhận dịch vụ và thông tin theo cách đáp ứng nhu cầu của quý vị

Chúng tôi phải đảm bảo **tất cả** các dịch vụ được cung cấp cho quý vị theo cách có thể tiếp cận và phù hợp về mặt văn hóa. Chúng tôi phải cho quý vị biết các quyền lợi của chương trình chúng tôi và quyền của quý vị theo cách mà quý vị có thể hiểu được. Chúng tôi phải cho quý vị biết quyền của quý vị mỗi năm khi quý vị tham gia chương trình chúng tôi.

- Để được cấp thông tin bằng những hình thức quý vị hiểu được, xin gọi cho ban Dịch Vụ Hội Viên. Chương trình chúng tôi hiện có dịch vụ thông dịch miễn phí để giải đáp các thắc mắc bằng các ngôn ngữ khác nhau.
- Hiện có dịch vụ thông dịch. Để có thông dịch viên, chỉ cần gọi chúng tôi theo số 1-833-522-3767 (TTY: 711), 24 giờ trong ngày, 7 ngày trong tuần, kể cả ngày lễ.
- Chương trình chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng những ngôn ngữ khác ngoài tiếng Anh và bằng những hình thức khác như bản in chữ khổ lớn, chữ nổi braille hoặc băng đĩa thu âm. Quý vị có thể lấy thông tin này miễn phí bằng tiếng Ả Rập, tiếng Ac-mê-ni-a, tiếng Cam-pu-chia (tiếng Khmer), tiếng Hoa, tiếng Ba Tư, tiếng Hàn, tiếng Nga, tiếng Tây Ban Nha, tiếng Tagalog và tiếng Việt. Để lấy tài liệu bằng một trong những hình thức này, vui lòng gọi hay viết thư cho:

L.A. Care Medicare Plus
Attn: Member Services Department
1055 West 7th Street
Los Angeles, CA 90017

- Ngay bây giờ hay trong tương lai, nếu quý vị muốn nhận được tài liệu bằng một ngôn ngữ không phải tiếng Anh hoặc bằng một hình thức khác, xin gọi cho ban Dịch Vụ Hội Viên theo số 1-833-522-3767 (TTY: 711), 24 giờ trong ngày, 7 ngày trong tuần, kể cả ngày lễ. Cuộc gọi này được miễn cước.
- Hội viên có quyền đưa ra các đề nghị liên quan đến chính sách về quyền và trách nhiệm của hội viên thuộc tổ chức

Nếu quý vị gặp khó khăn trong việc lấy thông tin chương trình chúng tôi vì vấn đề ngôn ngữ hoặc do tình trạng khuyết tật, và quý vị muốn khiếu nại, xin gọi:

- Medicare theo số 1-800-MEDICARE (1-800-633-4227). Quý vị có thể gọi 24 giờ trong ngày, 7 ngày trong tuần. Người dùng TTY nên gọi 1-877-486-2048.
- Bộ Dịch Vụ Y Tế và Nhân Sinh Hoa Kỳ, Văn Phòng Dân Quyền theo số 1-800-368-1019. Người dùng TTY nên gọi 1-800-537-7697.
- Văn Phòng Dân Quyền của Medi-Cal theo số 1-916-440-7370. Người dùng TTY vui lòng gọi 711.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



A. حقك في الحصول على الخدمات والمعلومات بطريقة تلبى احتياجاتك

يجب أن نتأكد من تقديم كافة الخدمات لك بطريقة ملائمة ثقافياً ويمكن الوصول إليها. يجب أن نخبرك عن مزاياك في الخطة وحقوك بطريقة يمكنك فهمها. يجب أن نخبرك عن حقوقك كل سنة تكون فيها عضواً في خطتنا.

- للحصول على معلومات بطريقة يمكنك فهمها، اتصل بخدمات الأعضاء. تتضمن خطتنا خدمات مترجم فوري مجانية متاحة للإجابة على أسئلة بلغات مختلفة.
- خدمات الترجمة الفورية متوفرة. وللحصول على خدمة مترجم فوري، فقط اتصل بنا على الرقم 1-833-522-3767 (TTY: 711)، على مدار 24 ساعة يومياً و 7 أيام في الأسبوع، بما في ذلك العطلات.
- وتمنحك خطتنا المواد بلغات أخرى غير اللغة الإنجليزية وبتنسيقات مثل الطباعة بأحرف كبيرة أو طريقة برايل أو ملفات صوتية. يمكنك الحصول على هذه المعلومات مجاناً باللغات العربية والأرمنية والكمبودية (الخميرية) والصينية والفارسية والكورية والروسية والإسبانية والتاغالوغية والفيتنامية. للحصول على مواد بإحدى هذه التنسيقات البديلة، يرجى الاتصال أو الكتابة إلى:

L.A. Care Medicare Plus
Attn: Member Services Department
7th Street 1055 West
90017 Los Angeles, CA

- إذا كنت ترغب في تلقي المواد بما في ذلك المواد الجديدة، الآن وفي المستقبل، بلغات غير اللغة الإنجليزية أو بتنسيق آخر، يُرجى اتصل مع خدمات الأعضاء على 1-833-522-3767 (TTY: 711)، على مدار 24 ساعة يومياً و 7 أيام في الأسبوع، بما في ذلك العطلات. المكالمات مجانية.
- يحق للأعضاء تقديم توصيات بشأن سياسة حقوق ومسؤوليات أعضاء المنظمة.

إذا كنت تواجه مشكلة في الحصول على معلومات من برنامجنا بسبب مشكلات لغوية أو إعاقة وتريد تقديم شكوى، اتصل مع:

- برنامج Medicare على 1-800-MEDICARE (1-800-633-4227). يمكنك الاتصال على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. ينبغي على مستخدمي TTY الاتصال على رقم 1-877-486-2048.
- اتصل بمكتب الحقوق المدنية التابع لوزارة الصحة والخدمات البشرية الأمريكية على الرقم 1-800-368-1019. يجب على مستخدمي TTY الاتصال بالرقم 1-800-537-7697.
- مكتب Medi-Cal للحقوق المدنية على 1-916-440-7370. يجب على مستخدمي TTY الاتصال على رقم 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 Member Services 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 Manager.

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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

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

Your PHI includes 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. L.A. Care Medicare Plus 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. L.A. Care Medicare Plus will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. L.A. Care Medicare Plus 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.

To make a confidential communications request, please contact member services at the phone number on your ID card.

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. If you have dual Medicare and Medi-Cal coverage, to better serve you and improve your health care, we may give Medi-Cal your health information. If Medi-Cal releases or uses your information, it will be done according to federal laws. Where required by law, when our business partners

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



work with us, they must also protect the privacy of any PHI we share with them and are not allowed to give PHI to others except as allowable by law, and this notice.

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 Member Services.

You can learn more about your privacy rights by requesting a copy of our Notice of Privacy Practices (NOPP). The NOPP is available on our website (www.medicare.lacare.org) or by calling Member Services.

D. Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. This is a free service to you. You can get member material for free in other languages, like Arabic, Armenian, Cambodian (Khmer), Chinese, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese. We can also give you information in large print, braille, or audio.

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

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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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.

L.A. County Area Agency on Aging

CALL: 1-800-510-2020

WRITE: 3175 West 6th Street
Los Angeles, CA 90020

EMAIL: Info@CSS.lacounty.gov

WEBSITE: <http://css.lacounty.gov>

- **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. L.A. Care Medicare Plus 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 Member Services for more information.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 the Department of Health Care Services Office of the Ombudsman 1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

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

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

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

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

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

- Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.
- The Health Insurance Counseling and Advocacy Program (HICAP) program at 1-800-434-0222 (TTY: 711). For more details about HICAP, refer to Chapter 2.
- 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.)



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

I. Your responsibilities as a plan member

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

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
 - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
 - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your 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 management team** 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.**



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- **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 drugs that our plan covers, you must pay your share of the cost when you get the drug.
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
 - **If you move outside of our service area you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* tells you about our service area.
 - We can help you find out if you're moving outside our service area.
 - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of 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 Member Services for help if you have questions or concerns.



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

Introduction

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

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

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the 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*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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

You can get help from the Office of the Patient Advocate

The Office of the Patient Advocate (OPA) can help you understand your rights, learn how to get health insurance, and choose quality care.

You can contact OPA by calling 1-888-466-2219 or emailing contactopa@opa.ca.gov. You can also visit the OPA website at <http://www.opa.ca.gov>.

You can also contact the Beneficiary and Family-Centered Care (BFCC) - Quality Improvement Organization (QIO)

You may also file a complaint with the Beneficiary and Family-Centered Care (BFCC) Quality Improvement Organization (QIO) for California, Livanta. You may contact the BFCC-QIO in writing at the following address:

Livanta
BFCC-QIO Program
10820 Guilford Rd. Suite 202
Annapolis Junction, MD 20701

You may also call: 1-877-588-1123 (TTY: 1-855-887-6668)

Livanta is available 9 a.m. – 5 p.m. Monday to Friday; Saturday, Sunday and Holidays, 11 a.m. – 3 p.m.

https://livantaqio.com/en/beneficiary/immediate_advocacy

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

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.

<p>Is your problem or concern about your benefits or coverage?</p> <p>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.</p>	
<p>Yes.</p> <p>My problem is about benefits or coverage.</p> <p>Refer to Section E, “Coverage decisions and appeals.”</p>	<p>No.</p> <p>My problem is not about benefits or coverage.</p> <p>Refer to Section K, “How to make a complaint.”</p>

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.dmhca.gov. Refer to page 189 for more information.

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

If we say **No** to 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **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 Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.lacare.org. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

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

- **Section F**, “Medical care”
- **Section G**, “Medicare Part D prescription drugs”
- **Section H**, “Asking us to cover a longer hospital stay”



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- **Section I**, “Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)”

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

F. Medical care

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

This section is about your benefits for medical care 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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** 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: 1-833-522-3767 (TTY: 711).
- Faxing: 1-213-438-5748.
- Writing:
L.A. Care Medicare Plus
Attention: Appeals & Grievances - 348
1055 W 7th Street
Los Angeles, CA 90017

Standard coverage decision

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

- L.A. Care Medicare Plus will decide routine pre-approvals for Medical service or item within 5 working days, of when L.A. Care Medicare Plus gets the information needed to make a decision, and no later than 14 calendar days after L.A. Care Medicare Plus receives the 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**.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- 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 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

- 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 or on our website at medicare.lacare.org.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 41 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

(1) 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 160 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.

If you still do not agree with this decision, you can:

* Ask for an Independent Medical Review and an outside reviewer that is not related to the health plan will review your case.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

* Ask for a State Hearing and a judge will review your case.

You can ask for both an Independent Medical Review and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an Independent Medical Review first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, and the State Hearing has already taken place, then you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or State Hearing.

INDEPENDENT MEDICAL REVIEW

If you want an Independent Medical Review, you must ask for one within 180 days from the date of this Notice of Appeal Resolution letter. The paragraph below will provide you with information on how to request an Independent Medical Review.¹ Note that the term “grievance” is talking about both “complaints” and “appeals.”

“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 **1-833-522-3767** (TTY: **711**) and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an 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.”

STATE HEARING

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan’s appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request for a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is decided. You should contact L.A. Care Member Services by calling 1-833-522-3767, 24 hours a day, 7 days a week. If you cannot hear or speak well, please call TTY 711.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

You can ask for a State Hearing in the following ways:

*Online at www.cdss.ca.gov

*By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

*In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

Mail: California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Fax: 1-916-309-3487 or toll-free 1-833-281-0903

A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak on for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the Los Angeles County Department of Consumer and Business Affairs 1-800-593-8222. You may also call the local Legal Aid Society in your county at 1-888-804-3536.

The Fair Hearing office gives you their decision in writing and explain the reasons.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 the *drug categories that require a copay*.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund 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 you the payment *or if the plan has cost sharing*, 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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.) Start with Section G2 , then refer to Sections G3 and G4 .	You can ask us for a coverage decision. Refer to Section G4 .	You can ask us to pay you back. (This is a type of coverage decision.) Refer to Section G4 .	You can make an appeal. (This means you ask us to reconsider.) 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 drugs in Tier 4 for brand name drugs or for generic 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 5 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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 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 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays, 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays, 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Member Services at the numbers at the bottom of the page. You can also call 1800-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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (1800-633-4227), 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 1-877-588-1123 (TTY: 1-855-887-6668). 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

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 160 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.

Ask for a fast review. Act quickly and contact the 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 Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Within one full day after getting all of the information it needs, the 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



- 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 1-877-588-1123 (TTY: 1-855-887-6668).

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 154 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 Member Services 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 160 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



If you think we're ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
 - Call Member Services at the numbers at the bottom of the page.
 - Call the 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 160 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

The legal term for the written notice is **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

13. 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 1-877-588-1123 (TTY: 1-855-887-6668).

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 160 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.

14. Making a Level 1 Alternate Appeal

As explained in **Section 12**, 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 Member Services at the numbers at the bottom of the page and ask us for a "fast review."



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

15. 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 160 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 you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

- 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 have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

If you still do not agree with this decision, you can:

- * Ask for an Independent Medical Review and an outside reviewer that is not related to the health plan will review your case.
- * Ask for a State Hearing and a judge will review your case.

You can ask for both an Independent Medical Review and State Hearing at the same time. You can also ask for one before the other to see if it will resolve your problem first. For example, if you ask for an Independent Medical Review first, but do not agree with the decision, you can still ask for a State Hearing later. However, if you ask for a State Hearing first, and the State Hearing has already taken place, then you cannot ask for an Independent Medical Review. In this case, the State Hearing has the final say.

You will not have to pay for an Independent Medical Review or State Hearing.

INDEPENDENT MEDICAL REVIEW

If you want an Independent Medical Review, you must ask for one within 180 days from the date of this Notice of Appeal Resolution letter. The paragraph below will provide you with information on how to request an Independent Medical Review.¹ Note that the term “grievance” is talking about both “complaints” and “appeals.”

“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 **1-833-522-3767** (TTY: **711**) and use your health plan’s grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department’s internet website **www.dmhca.gov** has complaint forms, IMR application forms, and instructions online.”

STATE HEARING

If you want a State Hearing, you must ask for one within 120 days from the date of this Notice of Appeal Resolution letter. However, if your health plan continued to provide you with the disputed service(s) (Aid Paid Pending) during the health plan’s appeal process and you want the service(s) to continue until there is a decision on your State Hearing, you must request for a State Hearing within 10 days of this Notice of Appeal Resolution letter. Even though your health plan must give you Aid Paid Pending when you ask for a State Hearing in this way, you should let your health plan know you want to get Aid Paid Pending until your State Hearing is



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

decided. You should contact L.A. Care Member Services by calling 1-833-522-3767, 24 hours a day, 7 days a week. If you cannot hear or speak well, please call TTY 711.

You can ask for a State Hearing in the following ways:

* Online at www.cdss.ca.gov

* By phone: Call 1-800-743-8525. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call TTY/TDD 1-800-952-8349.

* In writing: Fill out a State Hearing form or write a letter. Send it by mail or fax to:

Mail: California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 9-17-37
Sacramento, CA 94244-2430
Fax: 1-916-309-3487 or toll-free 1-833-281-0903

A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number and/or CIN number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell the State Hearings Division what language you speak. You will not have to pay for an interpreter. The State Hearings Division will get you one. If you have a disability, the State Hearings Division can get you special accommodations free of charge to help you participate in the hearing. Please include information about your disability and the accommodation you need.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an Expedited Hearing and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearings Division that the person is allowed to speak on for you. This person is called an Authorized Representative.

LEGAL HELP

You may be able to get free legal help. Call the Los Angeles County Department of Consumer and Business Affairs 1-800-593-8222. You may also call the local Legal Aid Society in your county at 1-888-804-3536.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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	<ul style="list-style-type: none"> • You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.
Accessibility and language assistance	<ul style="list-style-type: none"> • You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



Complaint	Example
Waiting times	<ul style="list-style-type: none"> You have trouble getting an appointment or wait too long to get it. Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	<ul style="list-style-type: none"> You think the clinic, hospital or doctor's office is not clean.
Information you get from us	<ul style="list-style-type: none"> You think we failed to give you a notice or letter that you should have received. You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	<ul style="list-style-type: none"> You think we don't meet our deadlines for making a coverage decision or answering your appeal. You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. You don't think we sent your case to the 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 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays.

You can send your complaint to Medicare for external complaints.

The Medicare Complaint Form is available at:

www.medicare.gov/MedicareComplaintForm/home.aspx.

The legal term for a "complaint" is a "**grievance.**"

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

K2. Internal complaints

To make an internal complaint, call Member Services at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. 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, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- Grievances and Appeals can be submitted using the following methods:
 - Phone:** 1-833-522-3767 (TTY 711), 24 hours a day, 7 days a week, including holidays
Fax: 1-213-438-5748
 - Mail:** L.A. Care Health Plan
Attention: Appeals & Grievances - 348
1055 W 7th Street
Los Angeles, CA 90017
 - Online:** <https://www.lacare.org/online-grievance-form>
- In the event that a member would like someone to act on their behalf (e.g. relative, lawyer), an Appointment of Representative (AOR) form must be completed <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> and sent to L.A. Care through fax or the mailing address listed above. A treating physician of the member does not have to complete the AOR form when filing an Appeal on behalf of the member.
- Timeframes for Filing Grievances and Appeals

Appeals

Part C (Reconsideration)

- The member has 60 days from the date of denial to submit an appeal. Appeals may be accepted beyond the 60 days with good cause.
- Expedited Timeframe: 72 hours
- Standard Timeframe: pre-service 30 days/post-service 60 days

Part D (Redeterminations)

- The member has 60 days from the date of denial to submit an appeal. Appeals may be accepted beyond the 60 days with good cause.
- Expedited Timeframe: 72 hours
- Standard Timeframe: 7 day



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.lacare.org).

Grievances

Part D

- The member can file a grievance or expression of dissatisfaction at any time.

All Other Complaints

- The member can file a complaint or expression of dissatisfaction at any time.
- Expedited Timeframe: 24 hours
- Standard Timeframe: 30 days

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 L.A. Care Medicare Plus 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

You may also contact the local Office for Civil Rights office at:

WRITE: Office for Civil Rights

U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

CALL: 1-800-368-1019

TDD: 1-800-537-7697

FAX: 1-202-619-3818

You may also have rights under the Americans with Disability Act and under any applicable state law. You can contact the 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 1-877-588-1123 (TTY: 1-855-887-6668).



Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you 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*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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**.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

You can get more information about how you can end your membership by calling:

- Member Services 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 201.
- 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.
- Unless you have moved out of your county, your Medi-Cal membership will continue with L.A. Care Medicare Plus.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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.

<p>1. You can change to: Another Medicare health plan</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. For PACE inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. <p>OR</p> <p>Enroll in a new Medicare plan.</p> <p>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins.</p> <p>Unless you have moved out of your county, your Medi-Cal membership will continue with L.A. Care Medicare Plus.</p>
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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. <p>OR</p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p> <p>Your Medi-Cal plan will not change.</p>
<p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>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.</p> <p>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/.</p>	<p>Here is what to do:</p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"> • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. <p>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p> <p>Your Medi-Cal plan will not change.</p>



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in L.A. Care Medicare Plus 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. Our plan is only for people who qualify for both Medicare and Medi-Cal. The California Department of Health Care Services (DHCS) or the Centers for Medicare and Medicaid Services (CMS) may disenroll you from Medi-Cal if it is determined that you are no longer eligible for the program.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, call Member Services 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

If you no longer qualify for Medi-Cal or your circumstances have changed that make you no longer eligible for Dual-eligible Special Needs Plan, you may continue to get your benefits from L.A. Care Medicare Plus Plan for an additional three-month period. This additional time will allow you to correct your eligibility information if you believe that you are still eligible. You will get a letter from us about the change in your eligibility with instructions to correct your eligibility information.

- To stay a member of L.A. Care Medicare Plus Plan, you must qualify again by the last day of the three-month period.

If you do not qualify by the end of the three-month period, you'll be disenrolled from L.A. Care Medicare Plus Plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

Discrimination is against the law. L.A. Care Health Plan follows State and Federal civil rights laws. L.A. Care Health Plan does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

L.A. Care Health Plan provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free 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 L.A. Care Health Plan 24 hours a day, 7 days a week, including holidays, by calling 1-833-522-3767. If you cannot hear or speak well, please call TTY 711. Upon request, this document can be made available to you in braille, large print, audio cassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

L.A. Care Health Plan
Member Services Department
1055 West 7th Street, 10th Floor
Los Angeles, CA 90017
1-833-522-3767 TTY: 711

HOW TO FILE A CIVIL RIGHTS GRIEVANCE

If you believe that L.A. Care Health Plan has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with L.A. Care Health Plan Chief Compliance Officer. You can file a civil rights grievance by phone, in writing, in person, or electronically:

- By phone: Contact L.A. Care Health Plan Chief Compliance Officer, 24 hours a day, 7 days a week, including holidays, by calling 1-833-522-3767. Or, if you cannot hear or speak well, please call TTY 711.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- In writing: Fill out a complaint form or write a letter and send it to:

L.A. Care Health Plan
 Chief Compliance Officer
 1055 West 7th Street, 10th Floor
 Los Angeles, CA 90017

Email: civilrightscoordinator@lacare.org

- In person: Visit your doctor's office or L.A. Care Health Plan and say you want to file a civil rights grievance.
- Electronically: Visit L.A. Care Health Plan website at www.lacare.org/members/member-support/file-grievance/grievance-appeal-form

or send an email to civilrightscoordinator@lacare.org.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call 1-800-368-1019. If you cannot speak or hear well, please call TTY/TDD 1-800-537-7697.
- In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
 200 Independence Avenue, SW
 Room 509F, HHH Building
 Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

- Electronically: Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

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).



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

- 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 Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Medi-Cal is the payer of last resort.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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 Manager: 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.

If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.



Copay: A fixed amount you pay as your share of the cost each time you get certain prescription drugs. For example, you might pay \$2 or \$5 for a prescription drug.

Cost sharing: Amounts you have to pay when you get certain prescription drugs. Cost sharing includes copays.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of five (5) 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.

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 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 (5) tiers.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Manager 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 Member Services 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. The plan of care developed by a D-SNP Member and the Member's Interdisciplinary Care Team (ICT). Also called Care Plan.

Initial coverage stage: The stage before your total Part D drug expenses reach \$7,400. 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, social workers, 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."



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

Managed Long-term services and supports (MLTSS): Managed 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. MLTSS include Community Based Adult Services (CBAS) and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help."

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medi-Cal: This is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- 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. The State's definition of medically necessary medical services includes services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to reduce or get rid of severe pain.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan").

Medicare Advantage: 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.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit [medicare.lacare.org](https://www.medicare.lacare.org).

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.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.



If you have questions, please call L.A. Care Medicare Plus at 1-833-522-3767 (TTY: 711), 24 hours a day, 7 days a week, including holidays. The call is free. **For more information**, visit medicare.lacare.org.

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 outofnetwork 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.



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Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. Refer to the definition for “cost sharing” above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to “Medicare Part A.”

Part B: Refer to “Medicare Part B.”

Part C: Refer to “Medicare Part C.”

Part D: Refer to “Medicare Part D.”

Part D drugs: Refer to “Medicare Part D drugs.”

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Member Handbook* for information about getting care from primary care providers.

Prior authorization: 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*.



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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.



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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.

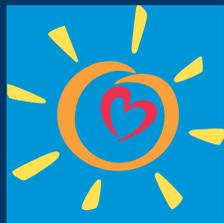


L.A. Care Medicare Plus **Member Services**

CALL	1-833-522-3767 Calls to this number are free. 24 hours a day, 7 days a week, including holidays. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week, including holidays.
FAX	1-213-438-5712
WRITE	L.A. Care Medicare Plus Attn: Member Services Department 1055 West 7th Street Los Angeles, CA 90017
WEBSITE	medicare.lacare.org



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