

**January 1 – December 31, 2012**

## **Evidence of Coverage:**

### **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Partnership*Advantage* (HMO SNP)**

This booklet gives you the details about your Medicare and Medi-Cal (Medicaid) health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Partnership*Advantage*, is offered by Partnership HealthPlan of California (PHC). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means PHC. When it says “plan” or “our plan,” it means Partnership*Advantage*.)

Partnership HealthPlan of California is a Medicare Advantage organization with a Medicare contract and a contract with the California Medi-Cal Program.

This information is available for free in other languages. Please contact our Member Services number at 866-264-3626 for additional information. (TTY users should call the California Relay Service at 800-735-2929 or dial 711). Hours are 8am to 8pm, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible sin costo en otros idiomas. Llame a nuestro número de Servicios al Miembro al 866-264-3626 para obtener más información. (Los usuarios de TTY deben llamar al California Relay Service al 800-735-2929 o marcar el 711). El horario es de 8:00 a.m. a 8:00 p.m., los siete días de la semana. Servicios al Miembro también tiene servicios gratuitos de intérprete disponibles para las personas que no hablan inglés.

This information is available for free in other formats (e.g. Braille, large print, audio CD) upon request. To receive this document in another format, please contact our Member Services number above.

Benefits, formulary, pharmacy network, premium, and/or copayments may change on January 1, 2013.

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## **2012 Evidence of Coverage**

### **Table of Contents**

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

<b>Chapter 1.</b>	<b>Getting started as a member.....</b>	<b>1</b>
	Tells what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.	
<b>Chapter 2.</b>	<b>Important phone numbers and resources .....</b>	<b>15</b>
	Tells you how to get in touch with our plan ( <i>PartnershipAdvantage</i> ) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medi-Cal (Medicaid) (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.	
<b>Chapter 3.</b>	<b>Using the plan’s coverage for your medical and other covered services .....</b>	<b>28</b>
	Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan’s network and how to get care when you have an emergency.	
<b>Chapter 4.</b>	<b>Benefits Chart (what is covered) .....</b>	<b>44</b>
	Gives the details about which types of medical care are covered and <i>not</i> covered for you as a member of our plan.	
<b>Chapter 5.</b>	<b>Using the plan’s coverage for your Part D prescription drugs .....</b>	<b>74</b>
	Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan’s <i>List of Covered Drugs (Formulary)</i> to find out which drugs are covered. Tells which kinds of drugs are <i>not</i> covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan’s programs for drug safety and managing medications.	

<b>Chapter 6.</b>	<b>What you pay for your Part D prescription drugs .....</b>	<b>95</b>
	Tells about the three (3) stages of drug coverage ( <i>Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage</i> ) and how these stages affect what you pay for your drugs. Explains the two (2) cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier.	
<b>Chapter 7.</b>	<b>Asking us to pay a bill you have received for covered medical services or drugs .....</b>	<b>111</b>
	Tells when and how to send a bill to us when you want to ask us to pay you back for your covered services or drugs.	
<b>Chapter 8.</b>	<b>Your rights and responsibilities .....</b>	<b>117</b>
	Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.	
<b>Chapter 9.</b>	<b>What to do if you have a problem or complaint (coverage decisions, appeals, complaints) .....</b>	<b>136</b>
	Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.	
	<ul style="list-style-type: none"><li>• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.</li><li>• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.</li></ul>	
<b>Chapter 10.</b>	<b>Ending your membership in the plan .....</b>	<b>195</b>
	Tells when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.	
<b>Chapter 11.</b>	<b>Legal notices .....</b>	<b>201</b>
	Includes notices about governing law and about nondiscrimination.	
<b>Chapter 12.</b>	<b>Definitions of important words .....</b>	<b>203</b>

Explains key terms used in this booklet.

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## **Chapter 1. Getting started as a member**

<b>SECTION 1</b>	<b>Introduction .....</b>	<b>3</b>
Section 1.1	You are enrolled in <i>PartnershipAdvantage</i> , which is a specialized Medicare Advantage Plan (Special Needs Plan) .....	3
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about? .....	3
Section 1.3	What does this Chapter tell you? .....	4
Section 1.4	What if you are new to <i>PartnershipAdvantage</i> ?.....	4
Section 1.5	Legal information about the <i>Evidence of Coverage</i> .....	4
<b>SECTION 2</b>	<b>What makes you eligible to be a plan member?.....</b>	<b>5</b>
Section 2.1	Your eligibility requirements .....	5
Section 2.2	What are Medicare Part A and Medicare Part B?.....	5
Section 2.3	What is Medi-Cal ? .....	5
Section 2.4	Here is the plan service area for <i>PartnershipAdvantage</i> .....	6
<b>SECTION 3</b>	<b>What other materials will you get from us? .....</b>	<b>6</b>
Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs.....	6
Section 3.2	The <i>Provider Directory</i> : Your guide to all providers and pharmacies in the plan’s network.....	8
Section 3.3	The plan’s <i>List of Covered Drugs (Formulary)</i> .....	9
Section 3.4	The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs .....	10
<b>SECTION 4</b>	<b>Your monthly premium for <i>PartnershipAdvantage</i>.....</b>	<b>10</b>
Section 4.1	How much is your plan premium?.....	10
Section 4.2	Can we change your monthly plan premium during the year? .....	11

<b>SECTION 5</b>	<b>Please keep your plan membership record up to date .....</b>	<b>11</b>
Section 5.1	How to help make sure that we have accurate information about you .....	11
<b>SECTION 6</b>	<b>We protect the privacy of your personal health information.....</b>	<b>13</b>
Section 6.1	We make sure that your health information is protected .....	13
<b>SECTION 7</b>	<b>How other insurance works with our plan .....</b>	<b>13</b>
Section 7.1	Which plan pays first when you have other insurance?.....	13

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>You are enrolled in <i>PartnershipAdvantage</i>, which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
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You are covered by both Medicare and Medi-Cal (California's Medicaid program):

- **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).
- **Medi-Cal** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medi-Cal coverage varies depending on the state and the type of Medi-Cal you have. Some people with Medi-Cal get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our plan, *PartnershipAdvantage*.

There are different types of Medicare health plans. *PartnershipAdvantage* is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. *PartnershipAdvantage* is designed specifically for people who have Medicare and who are also entitled to assistance from Medi-Cal.

Because you get assistance from Medi-Cal, you will pay less for some of your Medicare health care services. Medi-Cal also provides other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive Extra Help from Medicare to pay for the costs of your Medicare prescription drugs. *PartnershipAdvantage* will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

*PartnershipAdvantage* is run by a non-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the California Medi-Cal (Medicaid) program to coordinate your Medi-Cal benefits. We are pleased to be providing your Medicare and Medi-Cal health care coverage, including your prescription drug coverage.

<b>Section 1.2</b>	<b>What is the <i>Evidence of Coverage</i> booklet about?</b>
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This *Evidence of Coverage* booklet tells you how to get your Medicare and Medi-Cal medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, *PartnershipAdvantage*, is offered by Partnership HealthPlan of California (PHC). (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means PHC. When it says “plan” or “our plan,” it means *PartnershipAdvantage*.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of *PartnershipAdvantage*.

### **Section 1.3      What does this Chapter tell you?**

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

### **Section 1.4      What if you are new to *PartnershipAdvantage*?**

If you are a new member, then it’s important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

*If you are confused or concerned or just have a question, please contact our plan’s Member Services (contact information is on the back cover of this booklet).*

### **Section 1.5      Legal information about the *Evidence of Coverage***

#### **It’s part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how *PartnershipAdvantage* covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in *PartnershipAdvantage* between January 1, 2012 and December 31, 2012.

#### **Medicare must approve our plan each year**

Medicare (the Centers for Medicare & Medicaid Services) must approve *PartnershipAdvantage* each year. You can continue to get Medicare coverage as a member of our plan only as long as

we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

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## **SECTION 2      What makes you eligible to be a plan member?**

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<b>Section 2.1      Your eligibility requirements</b>
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*You are eligible for membership in our plan as long as:*

- You live in our geographic service area (section 2.3 below describes our service area)
- -- *and* -- you are entitled to Medicare Part A
- -- *and* -- you are enrolled in Medicare Part B
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- *and* -- you meet the special eligibility requirements described below.

### **Special eligibility requirements for our plan**

Our plan is designed to meet the needs of people who receive certain Medi-Cal (Medicaid) benefits. (Medi-Cal is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for Medicare and Full Medi-Cal Benefits, and enrolled in PHC's Medi-Cal health plan in Solano, Napa or Yolo County.

<b>Section 2.2      What are Medicare Part A and Medicare Part B?</b>
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When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

<b>Section 2.3      What is Medi-Cal?</b>
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Medi-Cal is a joint Federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for

services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medi-Cal that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

## Section 2.4 Here is the plan service area for *PartnershipAdvantage*

Although Medicare is a Federal program, *PartnershipAdvantage* is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in California: Napa County, Solano County and Yolo County

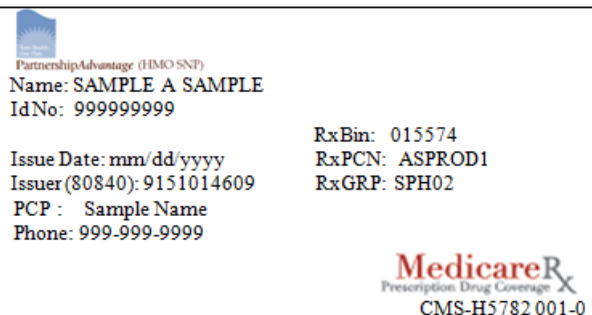
If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.


## SECTION 3 What other materials will you get from us?

### Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your *PartnershipAdvantage* membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:


Member Services Department: 866-264-3626; TTY 800-735-2929  
\*Member Advice Nurse Line: 866-778-8873  
\*Emergency: Call 911 or go to the nearest emergency room.  
\*Pharmacy Claims/Authorizations: MedImpact 800-926-3841.  
\*All other Claims: *PartnershipAdvantage* (HMO SNP)  
PO BOX 610, Suisun City, CA 94585-0610 707-863-4130.  
\*Medical Authorizations: 707-863-4133  
\*Mental Health/Substance Abuse: USBHPC 800-985-6904  
\*Eligibility Verification: To confirm eligibility and PCP assignment, call 707-863-4140 or 800-557-5471 or visit the website at: [www.partnershiphp.org](http://www.partnershiphp.org) to confirm eligibility.



  
PartnershipAdvantage (HMO SNP)  
Name: SAMPLE A SAMPLE  
IdNo: 999999999

Issue Date: mm/dd/yyyy  
Issuer (80840): 9151014609  
PCP: Sample Name  
Phone: 999-999-9999

RxBin: 015574  
RxPCN: ASPROD1  
RxGRP: SPH02

  
Prescription Drug Coverage  
CMS-H5782 001-0

As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Also, you must not use your blue and white California Benefits Identification Card (BIC) or your burgundy and white PHC Medi-Cal card. Your *PartnershipAdvantage* card allows you to access your Medicare and Medi-Cal (Medicaid) benefits through PHC, except as described above and later in this EOC.

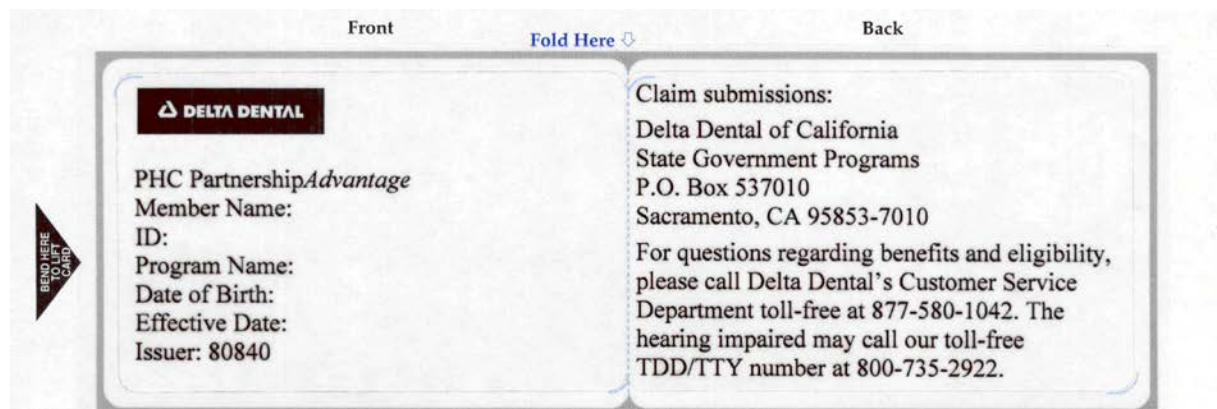
**Here's why this is so important:** If you get covered services using your red, white, and blue Medicare card, your BIC card or your PHC Medi-Cal card instead of using your *PartnershipAdvantage* membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

### Dental Benefits Member Identification Card

In order to receive your covered dental services under *PartnershipAdvantage* (HMO SNP), you will need to use your Delta Dental membership card. If you have not received this card, or have lost this card call Delta Dental toll free at (877) 580-1042 and a Delta Dental Customer Services Representative will assist you. TTY for the hearing impaired should call toll free (800) 735-2922 or call 711. Please show your Delta Dental Identification Card to your network dentist when you receive dental care.

Only the member is authorized to obtain dental services using his or her identification card. If a card is used by or for an individual other than the member, that individual will be billed for the services he or she receives. Additionally, if you let someone else use your identification card, Delta Dental may not be able to keep you in the program.



<b>Section 3.2</b>	<b>The <i>Provider Directory</i>: Your guide to all providers and pharmacies in the plan’s network</b>
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Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory*. This directory lists our network providers that accept Medicare and Medi-Cal reimbursement from PHC and lists our network pharmacies.

### **What are “network providers”?**

**Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

### **Why do you need to know which providers are part of our network?**

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which *PartnershipAdvantage* authorizes use of out-of-network providers. Remember, PHC is providing both your Medicare and Medi-Cal benefits through *PartnershipAdvantage*. See Chapter 3 (*Using the plan’s coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

It is important that you use network providers, as described above. These providers accept Medicare and Medi-Cal reimbursement from PHC. If you see an out-of-network provider for care, except for the exceptions listed above and later in this EOC, we may not pay for the care you receive and/or the provider may not accept Medi-Cal reimbursement from us.

If you don’t have your copy of the *Provider Directory*, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at [www.partnershiphp.org](http://www.partnershiphp.org), or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

### **What are “network pharmacies”?**

Our *Provider Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

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## Why do you need to know about network pharmacies?

You can use the *Provider Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Provider Directory*, you can get a copy from Member Services (phone numbers are on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at [www.partnershiphp.org](http://www.partnershiphp.org). Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

## About our Dental Network

*PartnershipAdvantage (HMO SNP)* works with Delta Dental to provide dental services to enrolled members.

As a member in this program, you have been sent an identification card, this handbook and a directory of participating dentists. Review the directory and look for the name of a network dentist in your area.

You can select any dentist listed in the directory. If you need help finding a dentist in your area or require assistance in finding a dentist, contact Delta Dental's Customer Service Department toll-free at the number listed in Chapter 2, Section 1.

To receive a copy of the dental provider directory, contact Delta Dental's Customer Service Department at the phone number listed above.

## Notifying You of Changes in the Dental Program

Delta Dental may send you updates about changes in the program. This can include updates for the *Provider Directory*. Delta Dental will keep you informed and are available to answer any questions you may have. Call Delta Dental at the number listed in Chapter 2, Section 1.

<b>Section 3.3</b> <b>The plan's <i>List of Covered Drugs (Formulary)</i></b>
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The plan has a *List of Covered Drugs (Formulary)*. We call it the "Formulary" for short. It tells which Part D prescription drugs are covered by *PartnershipAdvantage*. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the *PartnershipAdvantage* Formulary.

In addition to the drugs covered by Part D, some prescription drugs are covered for you under your Medi-Cal (Medicaid) benefits. The Formulary tells you how to find out which drugs are covered under Medi-Cal.

The Formulary also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Formulary. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.partnershiphp.org](http://www.partnershiphp.org)) or call Member Services (phone numbers are on the back cover of this booklet).

<b>Section 3.4</b>	<b>The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs</b>
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When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the “EOB”).

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

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## **SECTION 4**      **Your monthly premium for *PartnershipAdvantage***

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<b>Section 4.1</b>	<b>How much is your plan premium?</b>
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As a member of our plan, you pay a monthly plan premium. For 2012, the monthly premium for *PartnershipAdvantage* is \$78.40.

This premium is made up of two parts, for Part C and Part D. Your Part C premium of \$47.50 is paid for you by PHC Medi-Cal with zero cost share. Your Part D premium of \$30.90 is paid for by your Extra Help.

### **Some members are required to pay other Medicare premiums**

As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medi-Cal (Medicaid) as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most *PartnershipAdvantage* members, Medi-Cal pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medi-Cal is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called “2012 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2012* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

<b>Section 4.2</b>	<b>Can we change your monthly plan premium during the year?</b>
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**No.** We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

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<b>SECTION 5</b>	<b>Please keep your plan membership record up to date</b>
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<b>Section 5.1</b>	<b>How to help make sure that we have accurate information about you</b>
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan’s network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

**Let us know about these changes:**

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse’s employer, workers’ compensation, or Medi-Cal (Medicaid))
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are on the back cover of this booklet).

You should also report the following changes to your county Medi-Cal office:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation)
- If you have any liability claims, such as claims from an automobile accident
- If your designated responsible party (such as a caregiver) changes

Contact information for each county's Medi-Cal office is listed in Chapter 2, Section 6 of this EOC.

### **Read over the information we send you about any other insurance coverage you have**

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are on the back cover of this booklet).

### **Delta Dental Third Party Recovery process and Member responsibilities**

The member agrees that, if benefits of this program are provided to treat an injury or illness caused by the wrongful act or omission of another person or third party, provided that the member is made whole for all other damages resulting from the wrongful act or omission before the program is entitled to reimbursement, member shall:

- Reimburse the program for the reasonable cost of services paid by the program to the extent permitted by law immediately upon collection of damages by him or her, whether by action or law, settlement or otherwise; and
- Fully cooperate with the effectuation of the program's lien rights for the reasonable value of services provided to the extent permitted under state or federal law. The program's lien may be filed with the person whose act caused the injuries, his or her agent or the court. The program shall be entitled to payment, reimbursement, and subrogation in third party recoveries and member shall cooperate to fully and completely effectuate and protect these rights including prompt notification of a case involving possible recovery from a third party.

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## **SECTION 6      We protect the privacy of your personal health information**

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<b>Section 6.1      We make sure that your health information is protected</b>
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

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## **SECTION 7      How other insurance works with our plan**

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<b>Section 7.1      Which plan pays first when you have other insurance?</b>
--

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
  - If you’re under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you’re over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medi-Cal (Medicaid) and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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## **Chapter 2. Important phone numbers and resources**

<b>SECTION 1</b>	<b>Partnership <i>Advantage</i> contacts</b> (how to contact us, including how to reach Member Services at the plan).....	<b>16</b>
<b>SECTION 2</b>	<b>Medicare</b> (how to get help and information directly from the Federal Medicare program).....	<b>20</b>
<b>SECTION 3</b>	<b>State Health Insurance Assistance Program</b> (free help, information, and answers to your questions about Medicare) .....	<b>21</b>
<b>SECTION 4</b>	<b>Quality Improvement Organization</b> (paid by Medicare to check on the quality of care for people with Medicare).....	<b>22</b>
<b>SECTION 5</b>	<b>Social Security</b> .....	<b>23</b>
<b>SECTION 6</b>	<b>Medi-Cal (Medicaid)</b> (a joint Federal and state program that helps with medical costs for some people with limited income and resources) .....	<b>23</b>
<b>SECTION 7</b>	<b>Information about programs to help people pay for their prescription drugs</b> .....	<b>26</b>
<b>SECTION 8</b>	<b>How to contact the Railroad Retirement Board</b> .....	<b>27</b>
<b>SECTION 9</b>	<b>Do you have “group insurance” or other health insurance from an employer?</b> .....	<b>27</b>

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## **SECTION 1 PartnershipAdvantage contacts** (how to contact us, including how to reach Member Services at the plan)

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### **How to contact our plan's Member Services**

For assistance with claims, billing or member card questions, please call or write to PartnershipAdvantage Member Services. We will be happy to help you.

Our Member Services can help you with the following issues:

- **Contact us when you are asking for a coverage decision about your medical care**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

- **Contact us when you are asking for a coverage decision about your Part D prescription drugs**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

- **Send a request asking us to pay for our share of the cost for medical care or a drug you have received**

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*).

**Please note:** If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

<b>Member Services</b>	
<b>CALL</b>	866-264-3626  Calls to this number are free. 8am to 8pm, 7 days a week.  Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	800-735-2929 (through the California Relay Service, or CRS)  or dial 711  Calls to this number are free. 8am to 8pm, 7 days a week.
<b>FAX</b>	800-863-4415
<b>WRITE</b>	360 Campus Lane Suite 100 Fairfield, CA 94534  Attn: Member Services
<b>WEBSITE</b>	<a href="http://www.partnershiphp.org">www.partnershiphp.org</a>

### **How to contact our plan regarding Grievances and Appeals**

For assistance with grievances and appeals for your medical care or Part D prescription drugs, please call or write to PartnershipAdvantage Grievance Unit. We will be happy to help you.

Our Grievance Unit can help you with the following issues:

- **Contact us when you are making an appeal about your medical care**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

- **Contact us when you are making a complaint about your medical care**

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

- **Contact us when you are making an appeal about your Part D prescription drugs**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

- **Contact us when you are making a complaint about your Part D prescription drugs**

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

<b>Grievances and Appeals</b>	
<b>CALL</b>	866-264-3626  Calls to this number are free. 8am to 8pm, 7 days a week.  Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	800-735-2929 (through the California Relay Service, or CRS)  or dial 711  Calls to this number are free. 8am to 8pm, 7 days a week.
<b>FAX</b>	707-863-4306
<b>WRITE</b>	360 Campus Lane Suite 100 Fairfield, CA 94534  Attn: Grievance Unit

### **How to Contact Delta Dental**

Your introduction to the dental program begins with Delta Dental's Customer Service. This department can answer any questions you have about obtaining dental care and help you:

- Find a Network Dentist
- Receive assistance and information on all your dental plan services
- Questions about bills or statements you receive for dental services

A representative is available by telephone Monday through Friday, 8:00am to 8:00pm. You can contact Delta Dental's Customer Service by calling the toll-free number below. If you are hearing impaired, you may call our toll-free TTY number at (800) 735-2922 or call 711.

We want you to understand the dental program and its benefits, the services you can receive, the services that are not covered and any limitations on Covered Services.

This booklet will help you understand how the program works and how you obtain dental care. Please read this booklet completely and carefully before calling a Network Dentist to schedule your first examination. Keep this booklet in a convenient place or so you can refer to it again.

If you or your representative prefers to speak in any language other than English, call Delta Dental toll free at the number below and a Delta Dental Customer Service Representative will assist you.

<b>Delta Dental Customer Services</b>	
<b>CALL</b>	877-580-1042  Calls to this number are free. For claims, eligibility and benefit questions call Delta Dental's Customer Service Department toll-free at the number above. Customer Service Representatives are available Monday through Friday, 8:00am to 8:00pm to answer your questions.
<b>TTY</b>	800-735-2922 (California Relay Service) or call 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. Call Delta 8am to 8pm, Monday through Friday.
<b>WRITE</b>	P.O. Box 537010  Sacramento, CA 95853-7010
<b>WEBSITE</b>	<a href="http://www.deltadental.com">www.deltadental.com</a>  <a href="http://www.deltadentalins.com">www.deltadentalins.com</a>

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## **SECTION 2 Medicare** (how to get help and information directly from the Federal Medicare program)

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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 (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

<b>Medicare</b>	
<b>CALL</b>	1-800-MEDICARE, or 1-800-633-4227  Calls to this number are free.  24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>WEBSITE</b>	<a href="http://www.medicare.gov">http://www.medicare.gov</a>  This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”  The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none"><li>• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”</li><li>• <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance)</li></ul>

policies in your area. Select “Health & Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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### **SECTION 3      State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)

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The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called the Health Insurance and Counseling Advocacy Program (HICAP).

HICAP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<b>Health Insurance and Counseling Advocacy Program (HICAP) (California SHIP)</b>	
<b>CALL</b>	800-434-0222
<b>WRITE</b>	5380 Elvas Avenue Suite 221 Sacramento, CA 95819
<b>WEBSITE</b>	<a href="http://www.cahealthadvocates.org">www.cahealthadvocates.org</a>

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## **SECTION 4      Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)

---

There is a Quality Improvement Organization for each state. For California, the Quality Improvement Organization is called Health Services Advisory Group (HSAG).

HSAG has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. HSAG is an independent organization. It is not connected with our plan.

You should contact HSAG in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

<b>Health Services Advisory Group (California's Quality Improvement Organization)</b>	
<b>CALL</b>	800-841-1602
<b>TTY</b>	800-881-5980  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	Health Services Advisory Group, Inc. Attn: Beneficiary Protection 700 N. Brand Blvd, Suite 370 Glendale, CA 91203
<b>WEBSITE</b>	<a href="http://www.hsag.com/camedicare/index.asp">www.hsag.com/camedicare/index.asp</a>

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## **SECTION 5      Social Security**

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The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

<b>Social Security Administration</b>	
<b>CALL</b>	1-800-772-1213  Calls to this number are free.  Available 7:00 am to 7:00 pm, Monday through Friday.  You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.  Available 7:00 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">http://www.ssa.gov</a>

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## **SECTION 6      Medi-Cal (Medicaid)** (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. In California, this program is called Medi-Cal.

As a member of our plan, you already are enrolled with PHC for your Medi-Cal benefits, including Long Term Care, and other medical and prescription drug benefits not covered by Medicare. PHC offers Medi-Cal benefits to enrolled members through a contract with the State Medi-Cal Program: the California Department of Health Care Services.

In addition, there are programs offered through Medi-Cal that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).

If you have questions about the assistance you get from Medi-Cal, contact your local Medi-Cal office or the DHCS Office of the Ombudsman.

<b>Local Medi-Cal Offices</b>	
<b>CALL</b>	<p><u>For Napa County:</u> 707-253-4511</p> <p><u>For Solano County:</u> Fairfield – 707-784-8050 Vacaville – 707-469-4500 Vallejo – 707-553-5000</p> <p><u>For Yolo County:</u> Woodland – 530-661-2750 West Sacramento – 916-375-6200</p>
<b>WRITE</b>	<p><u>For Napa County:</u> Department of Health and Human Services 2261 Elm Street Napa, CA 94559</p> <p><u>For Solano County:</u> Call the numbers above for the nearest office</p> <p><u>For Yolo County:</u> Department of Employment and Social Services 25 N. Cottonwood Street Woodland, CA 95695</p> <p>Or, the West Sacramento office at:</p> <p>500-A Jefferson Blvd West Sacramento, CA 95605</p>

<b>WEBSITE</b>	For Napa County: <a href="http://countyofnapa.org/Pages/DepartmentContent.aspx?id=4294967830">http://countyofnapa.org/Pages/DepartmentContent.aspx?id=4294967830</a>
	For Solano County: <a href="http://www.solanocounty.com/depts/hss/ees/medical/medi_cal.asp">http://www.solanocounty.com/depts/hss/ees/medical/medi_cal.asp</a>
	For Yolo County: <a href="http://www.yolocounty.org/index.aspx?page=559">http://www.yolocounty.org/index.aspx?page=559</a>

The Medi-Cal Managed Care Office of the Ombudsman helps people enrolled in Medi-Cal with service or billing problems. They can help you file a grievance or appeal with our plan.

<b>California Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman</b>	
<b>CALL</b>	888-452-8609
<b>WRITE</b>	P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413
<b>WEBSITE</b>	<a href="http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx">http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOOfficeoftheOmbudsman.aspx</a>

The California Department of Aging, Office of the Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

<b>California Department of Aging Long-Term Care Ombudsman Program</b>	
<b>CALL</b>	800-231-4024 (CRISISline)
	For Napa County, call: 707-255-4236
	For Solano County, call: 707-644-4194
	For Yolo County, call: 916-376-8910; or 530-668-5775

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## **SECTION 7      Information about programs to help people pay for their prescription drugs**

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### **Medicare’s “Extra Help” Program**

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

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your Local Medi-Cal Office. (See Section 6 of this chapter for contact information)

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

- You can contact our Member Services at the number listed in Section 1 of this chapter to learn about what types of information you can provide to correct your co-payment level.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

### **Medicare Coverage Gap Discount Program**

Because you get “Extra Help” from Medicare to pay for your prescription drug plan costs, the Medicare Coverage Gap Discount Program does not apply to you. You already have coverage for your prescription drugs during the coverage gap through the Extra Help program.

For people who don’t get Extra Help, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap. These enrollees also receive some coverage for generic drugs. If you have any questions about the Medicare Coverage Gap Discount Program, please contact Member Services (phone numbers are on the back cover of this booklet).

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## SECTION 8      How to contact the Railroad Retirement Board

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The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
<b>CALL</b>	1-877-772-5772  Calls to this number are free.  Available 9:00 am to 3:30 pm, Monday through Friday  If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are <i>not</i> free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">http://www.rrb.gov</a>

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## SECTION 9      Do you have “group insurance” or other health insurance from an employer?

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If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

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

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## **Chapter 3. Using the plan's coverage for your medical and other covered services**

<b>SECTION 1</b>	<b>Things to know about getting your medical care and other services covered as a member of our plan.....</b>	<b>30</b>
Section 1.1	What are “network providers” and “covered services”?.....	30
Section 1.2	Basic rules for getting your medical care and other services covered by the plan.....	30
<b>SECTION 2</b>	<b>Use providers in the plan's network to get your medical care and other services .....</b>	<b>32</b>
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your care.....	32
Section 2.2	What kinds of medical care and other services can you get without getting approval in advance from your PCP? .....	34
Section 2.3	How to get care from specialists and other network providers.....	34
Section 2.4	How to get care from out-of-network providers .....	36
<b>SECTION 3</b>	<b>How to get covered services when you have an emergency or urgent need for care .....</b>	<b>36</b>
Section 3.1	Getting care if you have a medical emergency .....	36
Section 3.2	Getting care when you have an urgent need for care.....	37
<b>SECTION 4</b>	<b>What if you are billed directly for the full cost of your covered services? .....</b>	<b>38</b>
Section 4.1	You can ask the plan to pay our share of the cost for your covered services.....	38
Section 4.2	What should you do if services are not covered by our plan? .....	39
<b>SECTION 5</b>	<b>How are your medical services covered when you are in a “clinical research study”? .....</b>	<b>40</b>
Section 5.1	What is a “clinical research study”? .....	40

Section 5.2	When you participate in a clinical research study, who pays for what? .....	41
<b>SECTION 6</b>	<b>Rules for getting care covered in a “religious non-medical health care institution” .....</b>	<b>42</b>
Section 6.1	What is a religious non-medical health care institution? .....	42
Section 6.2	What care from a religious non-medical health care institution is covered by our plan? .....	42
<b>SECTION 7</b>	<b>Rules for ownership of durable medical equipment.....</b>	<b>43</b>
Section 7.1	Will you own your durable medical equipment after making a certain number of payments under our plan?.....	43

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## **SECTION 1      Things to know about getting your medical care and other services covered as a member of our plan**

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This chapter tells things you need to know about using the plan to get your medical care and other services covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Benefits Chart, what is covered*).

<b>Section 1.1      What are “network providers” and “covered services”?</b>
--

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services to members in our plan.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

<b>Section 1.2      Basic rules for getting your medical care and other services covered by the plan</b>
--

As a Medicare and Medi-Cal (Medicaid) health plan, Partnership *Advantage* must cover all services covered by Original Medicare and other services.

Partnership *Advantage* will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare or Medi-Cal requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- **The dental care you receive is included in this EOC, and received from network providers**
  - Dental coverage under Partnership *Advantage* is not designed to duplicate any dental benefits. Coverage provided under this program is primary to your Denti-Cal coverage, but secondary to any private dental coverage you may have. Benefits paid under this program are determined after benefits have been paid as a result of enrollment in any other dental care program that is the primary payer. By enrolling in the program each member agrees to complete and submit to Delta Dental such consents, releases, assignments and any other document reasonably requested by Delta Dental in order to assure and obtain reimbursement and to coordinate coverage with other dental plan or insurance policies. The payable benefits will be reduced when benefits are available to a member under such other plan or policy whether or not claim is made for the same.
  - Be sure to advise your dental provider of all programs under which you have coverage so that you will receive all benefits to which you are entitled. For further information, contact Delta Dental's Customer Services Department.

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## **SECTION 2      Use providers in the plan's network to get your medical care and other services**

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<b>Section 2.1      You must choose a Primary Care Provider (PCP) to provide and oversee your care</b>
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### **What is a “PCP” and what does the PCP do for you?**

A primary care provider is your personal doctor who will provide and arrange all of your medical health care needs. Your PCP will refer you to specialty care when needed. Your PCP will know your medical history and what medications you take.

When you become a member of Partnership *Advantage*, you must choose a plan provider to be your PCP. Your PCP meets state requirements and is trained to give you basic medical care. Your PCP may be assigned to a specific hospital and some specialists may only be available to members assigned to specific medical groups. Be sure to check with your PCP if you are interested in specific hospital and/or specialists.

### **What types of providers may act as a PCP?**

Your PCP may be an internist or a family practitioner, general practitioner or a pediatrician for children.

### **What is the role of a PCP in Partnership *Advantage*?**

You will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a Plan member. For example, in order to see a specialist, you usually need to get your PCP's approval first (this is called getting a “referral” to a specialist).

This includes:

- your x-rays
- laboratory tests
- therapies
- care from doctors who are specialists
- hospital admissions, and
- follow-up care

### **What is the role of the PCP in coordinating covered services?**

Coordinating your services includes checking or consulting with other Plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP

will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Chapter 8 tells you how we will protect the privacy of your medical records and personal health information.

### **How do you choose your PCP?**

At the time of enrollment, when you submit an application to join Partnership *Advantage*, you will be asked to select a PCP from a list of doctors. This list is called a Provider Directory. If the PCP you selected is accepting new patients, or if you are keeping the same PCP you had through Medi-Cal, your ID card will show the PCP you chose when you enrolled.

If you do not select a PCP at the time of enrollment, or the PCP you selected is not accepting new patients, our Member Services Department will contact you to help you select another PCP. If we are unable to contact you, we will assign you to the PCP on your Medi-Cal record with PHC.

### **Changing your PCP**

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

If you call our Member Services Department before the fifteenth of the month, you can start going to your new PCP the first of the following month.

### **How do you choose a dentist?**

You can choose any Network Dentist for your dental care. You must go to a network dentist because only the services by a participating dentist are covered by the program. If you go to a dentist who is not a network dentist (dentists who do not contract with Delta Dental for the program) you must pay all of the cost of treatment.

### **How do I schedule an appointment with a dentist?**

After you have selected a network dentist, call the dentist's office to schedule an appointment. Tell the dentist you are covered by PHC's Partnership *Advantage* program and ask the dentist to confirm that he or she is a participating provider in the program.

During your first appointment, be sure to give your dentist the following information:

1. Your program number (on your Delta Dental ID card): PAD-60;
2. Your identification number
3. Your date of birth; and,
4. Any other dental coverage you have

## Changing your dentist

You can choose any network dentist at any time. If you wish to change dentists, simply review the Provider Directory for dentists in your area and call to schedule an appointment.

<b>Section 2.2</b>	<b>What kinds of medical care and other services can you get without getting approval in advance from your PCP?</b>
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which 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.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

<b>Section 2.3</b>	<b>How to get care from specialists and other network providers</b>
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

### What is the role of my PCP in referring me to specialists and other providers?

In order to obtain services from specialists and other network providers, you must obtain a referral from your PCP. Some referrals must be approved by the Plan. For more information, contact our Member Services Department or see Section 2.1 in this Chapter for more details on services requiring a referral.

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## **For what services will my PCP need to get prior authorization from the Plan?**

Some services we offer require prior authorization. This means that our plan must pre-approve these services before you can get them. Your primary care provider is responsible for obtaining prior authorization from our plan.

Below is an example of some services that require prior authorization from the Partnership *Advantage*. See the Chapter 4, Section 2.1 in this EOC for information about which services require prior authorization.

## **Will my PCP selection limit me to specific specialists or hospitals to which my PCP refers?**

Sometimes, by joining a Medical Group, you will be referred to the group's specialists or the hospital associated with the group. In all cases, you will be limited to network providers, unless approved by the Plan.

## **What if a specialist or another network provider leaves our plan?**

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our network. If your PCP leaves our network, we will let you know and help you choose another PCP so that you can keep getting covered services.

In some circumstances when a doctor leaves, we make arrangements for members affected by the termination to continue care with their terminating doctor until their treatment is completed. In order for us to make these arrangements, the medical condition must meet specific criteria; the physician must be willing to continue seeing the member and must be willing to accept our rate of reimbursement.

## **Dental Benefit Utilization Review**

The goal of Delta Dental's Utilization Management (UM) program is to ensure that dental services provided to you are necessary and appropriate, the services are provided in an appropriate setting, the services are delivered in a timely manner and the services are provided in accordance with the scope of benefits of the program. The Delta Dental Utilization Review (UR) system includes an automated information processing system, employees who use that system, and policies and procedures that govern that usage.

The UR system identifies providers who have unusual treatment patterns, which require corrective action. Treatment patterns are accumulated through claim and encounter information submitted by providers, focus studies, dental facility reviews, dental chart reviews and member calls and grievances. The data is then analyzed to determine if any providers have unusual treatment patterns. If necessary, corrective action may include provider education, sanctions or even termination of a provider from Delta Dental's network.

Members may obtain information regarding Delta's UM/UR Program by contacting Delta Dental's Customer Service Department at the number listed in Chapter 2, Section 1.

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**Section 2.4      How to get care from out-of-network providers**

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Generally, you must receive care from in-network providers. There are circumstances where you may receive care from out-of-network providers. Please see Section 3 for more information.

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**SECTION 3      How to get covered services when you have an emergency or urgent need for care**

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**Section 3.1      Getting care if you have a medical emergency**

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**What is a “medical emergency” and what should you do if you have one?**

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call us at 866-264-3626 as soon as you are able to do so. TTY users should call 800-735-2929 or dial 711. You can reach us 8am to 8pm, seven days a week. These numbers are also found on the back of your Partnership *Advantage* ID card. Calls to these numbers are free.

**What is covered if you have a medical emergency?**

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

### **Medical Coverage Outside of the United States under Medi-Cal**

If you are outside of the United States, you are not covered by Medi-Cal, except for services requiring emergency hospitalization in Mexico or Canada.

#### **What if it wasn't a medical emergency?**

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

<b>Section 3.2</b>	<b>Getting care when you have an urgent need for care</b>
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#### **What is “urgently needed care”?**

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

#### **What if you are in the plan's service area when you have an urgent need for care?**

In most other situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

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## What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

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

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## SECTION 4 What if you are billed directly for the full cost of your covered services?

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<b>Section 4.1</b>	<b>You can ask the plan to pay for your covered services</b>
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If you have paid for your covered services *OR*, or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

### Dental Provider Payment

Delta Dental will pay network dentists directly. Their agreement with network dentists makes sure that you will not be responsible to the dentist for any money for a covered service listed in this booklet.

Your dentist does not receive payment for any procedure, which is a covered service, until the procedure is complete. Delta Dental does not pay network dentists any incentive as an inducement to deny, reduce, limit or delay any appropriate service.

If your network dentist files a claim for services more than six (6) months after the date you received these services, payment may be denied. If the payment is denied because your dentist failed to turn the claim in on time, you are not responsible for that payment.

Network Dentists must certify that the services listed on the treatment form have been personally provided to the patient by the dentist or, under their direction, by another person(s) eligible under the Program to provide such services, and such person(s) must be designated on the treatment form. The dentist must also certify that the services were, to the best of the dentist's knowledge, necessary to the health of the patient. The dentist must further acknowledge that they understand payment for services rendered will be made from Federal and/or State funds and that any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws.

The dentist agrees to file all claims for services provided to members and to submit such claims to Delta Dental within six (6) months after the date services were performed. Payment of claims for services will be issued directly to the Network Dentist.

Completed claim forms should be mailed to the following address:

Delta Dental of California  
State Government Programs  
P.O. Box 537010  
Sacramento, CA 95853-7010  
[www.deltadentalins.com/gov](http://www.deltadentalins.com/gov)

Delta Dental explains to all Network Dentists how they determine or deny payment for services. Delta Dental describes the dental procedures covered as benefits, the conditions under which coverage is provided, and the program's limitations and exclusions. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Network Dentist, you may be responsible for the payment. In the event Delta Dental fails to pay the dentist for Covered Services, you will not be responsible to the dentist for any money owed by the program.

<b>Section 4.2</b>	<b>What should you do if services are not covered by our plan?</b>
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Partnership *Advantage* covers all medical services that are medically necessary, are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service; unless that service is covered by Medi-Cal. You can call Member Services when you want to know how much of your benefit limit you have already used, and if any additional services will be covered by Medi-Cal.

### **Member Liabilities for Dental Services**

You must pay for any non-covered or optional dental services that you choose to have done. This program is designed to cover diagnostic and preventive dental treatment that is consistent with good professional practice. You will be responsible for services you receive that are not covered benefits as listed in this EOC and services received that are greater than the limits specified in this EOC.

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## SECTION 5      How are your medical services covered when you are in a “clinical research study”?

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<b>Section 5.1      What is a “clinical research study”?</b>
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this *Evidence of Coverage*).

<b>Section 5.2</b>	<b>When you participate in a clinical research study, who pays for what?</b>
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- 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 if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research study.

*Here's an example of how the cost sharing works:* Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but would be only \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study. Please see Chapter 7 for more information about submitting requests for payment.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

### **Do you want to know more?**

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<http://www.medicare.gov>). 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.

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## **SECTION 6 Rules for getting care covered in a “religious non-medical health care institution”**

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<b>Section 6.1</b>	<b>What is a religious non-medical health care institution?</b>
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

<b>Section 6.2</b>	<b>What care from a religious non-medical health care institution is covered by our plan?</b>
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is *not* voluntary or *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 you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

As described in the Benefits Chart in Chapter 4 of this document, the Medicare benefit limits inpatient hospital days to 90-days each benefit period. However, if the inpatient stay is medically

necessary and has been authorized by PHC there is no limit on hospital inpatient days through the Medi-Cal benefit.

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## **SECTION 7      Rules for ownership of durable medical equipment**

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<b>Section 7.1</b>	<b>Will you own your durable medical equipment after making a certain number of payments under our plan?</b>
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of Partnership *Advantage*, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Member Services (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

### **What happens to payments you have made for durable medical equipment if you switch to Original Medicare?**

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

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## **Chapter 4. Benefits Chart (what is covered)**

<b>SECTION 1</b>	<b>Understanding covered services.....</b>	<b>45</b>
Section 1.1	You pay nothing for your covered services .....	45
Section 1.2	What is the most you will pay for covered medical services? .....	45
<b>SECTION 2</b>	<b>Use the <i>Benefits Chart</i> to find out what is covered for you .....</b>	<b>45</b>
Section 2.1	Your medical benefits as a member of the plan.....	45
<b>SECTION 3</b>	<b>What benefits are not covered by the plan? .....</b>	<b>71</b>
Section 3.1	Benefits <i>not</i> covered by the plan (exclusions) .....	71

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## **SECTION 1      Understanding covered services**

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This chapter focuses on what services are covered. It includes a Benefits Chart that gives a list of your covered services as a member of Partnership *Advantage*. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services.

<b>Section 1.1      You pay nothing for your covered services</b>
---

Because you get assistance from Medi-Cal (Medicaid), you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (See Chapter 3 for more information about the plans' rules for getting your care.)

<b>Section 1.2      What is the most you will pay for covered medical services?</b>
---

**Note:** Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum.

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Partnership *Advantage*, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2012 is \$6,700.00. The amounts you pay for copayments for covered services count toward this maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$6,700.00, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medi-Cal or another third party).

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## **SECTION 2      Use the *Benefits Chart* to find out what is covered for you**

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<b>Section 2.1      Your medical benefits as a member of the plan</b>
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The Benefits Chart on the following pages lists the services Partnership *Advantage* covers. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- 
- Your Medicare and Medi-Cal (Medicaid) covered services must be provided according to the coverage guidelines established by Medicare and Medi-Cal.
  - Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
  - You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
  - You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.” Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
  - Some of the services listed in the Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk.
  - For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.

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

## Benefits Chart

Services that are covered for you

**What you must pay**  
when you get these  
services

### Inpatient Care

#### **Inpatient hospital care\***

You are covered for up to 90-days each benefit period. Inpatient hospital care is covered as long as you meet inpatient hospital care criteria. Covered services include:

- 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
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If Partnership *Advantage* provides transplant services at a distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of

There is no copayment for inpatient hospital care received in a network hospital.

If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, you may be responsible for the cost of unauthorized services.

You may qualify for additional benefit periods through Medi-Cal.

This service requires prior authorization, except in the event of an emergency.

Services that are covered for you	What you must pay when you get these services
<p>unreplaced blood. All other components of blood are covered beginning with the first pint used.</p> <ul style="list-style-type: none"><li>• Physician services</li></ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	

Services that are covered for you	What you must pay when you get these services
<p><b>Inpatient mental health care*</b></p> <ul style="list-style-type: none"><li>Covered services include mental health care services that require a hospital stay. Limited to 190 days each benefit period. The 190-day limit does not apply to Mental Health Services in a psychiatric unit of a general hospital.</li></ul>	<p>There is no copayment for inpatient mental health care.</p> <p>Except in an emergency, your provider must obtain authorization from U.S. Behavioral Health Plan of California (USBHPC). Call 800-985-6904.</p> <p>The phone number for USBHPC can also be found on the back of your Partnership <i>Advantage</i> ID card.</p> <p>You may qualify for additional benefit periods through Medi-Cal.</p> <p>This service requires prior authorization, except in the event of an emergency.</p>
<p><b>Skilled nursing facility (SNF) care*</b></p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>You are covered for up to 100 days each benefit period. SNF days are covered as long as you meet Medicare SNF criteria. Covered services include:</p> <ul style="list-style-type: none"><li>Semiprivate room (or a private room if medically necessary)</li></ul>	<p>There is no copayment for services received in a Skilled Nursing Facility.</p> <p>You may qualify for additional benefit periods through Medi-Cal.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• Meals, including special diets</li><li>• Regular nursing services</li><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li><li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.</li><li>• Medical and surgical supplies ordinarily provided by SNFs</li><li>• Laboratory tests ordinarily provided by SNFs</li><li>• X-rays and other radiology services ordinarily provided by SNFs</li><li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li><li>• Physician services</li></ul> <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"><li>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).</li><li>• A SNF where your spouse is living at the time you leave the hospital.</li></ul>	<p>This service requires prior authorization.</p>
<p><b>Home health agency care*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• 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</li></ul>	<p>There is no copayment for home health agency care.</p> <p>This service requires prior authorization.</p>

Services that are covered for you	What you must pay when you get these services
<p>must total fewer than 8 hours per day and 35 hours per week)</p> <ul style="list-style-type: none"><li>• Physical therapy, occupational therapy, and speech therapy</li><li>• Medical and social services</li><li>• Medical equipment and supplies</li></ul>	
<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Drugs for symptom control and pain relief</li><li>• Short-term respite care</li><li>• Home care</li></ul> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p> <ul style="list-style-type: none"><li>• You can obtain your non-hospice care from plan providers.</li><li>• --or-- You can get your care covered by Original Medicare.</li></ul> <p><b>Note:</b> If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. There is no cost sharing when you get your non-hospice care through our network providers</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 condition are paid for by Original Medicare, not <i>Partnership Advantage</i>.</p>
<b>Outpatient Services</b>	

Services that are covered for you	What you must pay when you get these services
<p><b>Physician services, including doctor's office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</li><li>• Consultation, diagnosis, and treatment by a specialist</li><li>• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment</li><li>• Telehealth office visits including consultation, diagnosis and treatment by a specialist</li><li>• Second opinion by another network provider prior to surgery</li><li>• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)</li></ul>	<p>There is no copayment for physician services.</p>
<p><b>Outpatient hospital services</b></p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Services in an emergency department or outpatient clinic, including same-day surgery</li><li>• Laboratory tests billed by the hospital</li><li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li><li>• X-rays and other radiology services billed by the hospital</li><li>• Medical supplies such as splints and casts</li><li>• Certain screenings and preventive services</li></ul>	<p>There is no copayment for outpatient hospital services.</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>Certain drugs and biologicals that you can't give yourself</li></ul> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p><b>Chiropractic services*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>We cover only manual manipulation of the spine to correct subluxation</li></ul>	<p>There is no copayment for chiropractic services.</p> <p>You may qualify for additional chiropractic services through Medi-Cal.</p> <p>This service requires prior authorization.</p>
<p><b>Podiatry services*</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li><li>Routine foot care for members with certain medical conditions affecting the lower limbs</li></ul>	<p>There is no copayment for podiatry services.</p> <p>You may qualify for additional podiatry services through Medi-Cal.</p> <p>This service requires prior authorization.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Outpatient mental health care*</b></p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>There is no copayment for outpatient mental health care.</p> <p>Please contact U.S. Behavioral Health Plan Care (USBHPC) to receive outpatient mental health care. Call 800-985-6904.</p> <p>The phone number for USBHPC can be found on the back of your Partnership <i>Advantage</i> ID card.</p>
<p><b>Partial hospitalization services*</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p> <p>Note: Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting.</p>	<p>There is no copayment for partial hospitalization services.</p> <p>This service requires prior authorization.</p>
<p><b>Outpatient substance abuse services*</b></p>	<p>There is no copayment for outpatient substance abuse services.</p> <p>This service requires prior authorization.</p>
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers*</b></p>	<p>There is no copayment for outpatient surgery, including services provided at hospital</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Note:</b> If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>outpatient facilities and ambulatory surgical centers.</p> <p>This service requires prior authorization.</p>
<p><b>Ambulance services</b></p> <ul style="list-style-type: none"><li>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan. The member’s condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.</li><li>• Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.</li></ul>	<p>There is no copayment for ambulance services.</p>
<p><b>Emergency care</b></p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Emergency care is only covered within the U.S. You may receive emergency care in Mexico or Canada through your Medi-Cal benefit.</p>	<p>There is no copayment for emergency care.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the</p>

Services that are covered for you	What you must pay when you get these services
	out-of-network hospital authorized by the plan.
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan’s network of providers is temporarily unavailable or inaccessible.</p> <p>Urgent care is only covered in the U.S.</p>	<p>There is no copayment for urgent care.</p>
<p><b>Outpatient rehabilitation services*</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>There is no copayment for rehabilitation services.</p> <p>This service requires prior authorization.</p>
<p><b>Cardiac rehabilitation services*</b></p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>There is no copayment for cardiac rehabilitation services.</p> <p>This service requires prior authorization.</p>
<p><b>Pulmonary rehabilitation services*</b></p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>There is no copayment for pulmonary rehabilitation services.</p> <p>This service requires prior authorization.</p>
<p><b>Durable medical equipment and related supplies*</b></p>	

Services that are covered for you	What you must pay when you get these services
<p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>There is no copayment for durable medical equipment and related supplies.</p> <p>This service requires prior authorization.</p>
<p><b>Prosthetic devices and related supplies*</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>There is no copayment for prosthetic devices and related supplies.</p> <p>This service requires prior authorization.</p>
<p><b>Diabetes self-management training, diabetic services and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> </ul>	<p>There is no copayment for diabetes self-management training, diabetic services and supplies.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include, but are not limited to:</p>	<p>There is no copayment for outpatient diagnostic tests and therapeutic services and</p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• X-rays</li><li>• Radiation (radium and isotope) therapy including technician materials and supplies</li><li>• Surgical supplies, such as dressings</li><li>• Splints, casts and other devices used to reduce fractures and dislocations</li><li>• Laboratory tests</li><li>• Blood. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.</li><li>• Other outpatient diagnostic tests</li></ul>	<p>supplies.</p> <p>The following services require prior authorization:</p> <ul style="list-style-type: none"><li>• CT scan</li><li>• MRI</li><li>• MRA</li><li>• PET scan</li><li>• Transcranial Doppler</li><li>• Sleep studies /polysomnography</li></ul>
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</li><li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</li><li>• One routine eye exam per year, up to \$100 benefit</li><li>• One pair of eyeglasses every two years, up to \$100 benefit</li><li>• The cost of lenses is included in the reimbursement of the eye exam. Replacements are available when medically necessary.</li></ul>	<p>There is no copayment for vision care.</p> <p>Services are covered through Vision Service Plan (VSP). A list of providers accepting VSP can be found in the provider directory.</p>
<p><b>Preventive Services</b></p>	
<p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply</p>	

Services that are covered for you	What you must pay when you get these services
for the care received for the existing medical condition.	
<b>Abdominal aortic aneurysm screening</b> A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.	There is no copayment for abdominal aortic aneurysm screening.
<b>Bone mass measurement</b> For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.	There is no copayment for bone mass measurement.
<b>Colorectal cancer screening</b> For people 50 and older, the following are covered: <ul style="list-style-type: none"><li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li><li>• Fecal occult blood test, every 12 months</li></ul> For people at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"><li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li></ul> For people not at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"><li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li></ul>	There is no copayment for colorectal cancer screening.

Services that are covered for you	What you must pay when you get these services
<p><b>HIV screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"><li>• One screening exam every 12 months</li></ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"><li>• Up to three screening exams during a pregnancy</li></ul>	<p>There is no copayment for HIV screening.</p>
<p><b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"><li>• Pneumonia vaccine</li><li>• Flu shots, once a year in the fall or winter</li><li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li><li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li></ul> <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>There is no copayment for immunizations.</p>
<p><b>Breast cancer screening (mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• One baseline mammogram between the ages of 35 and 39</li><li>• One screening mammogram every 12 months for women age 40 and older</li><li>• Clinical breast exams once every 24 months</li></ul>	<p>There is no copayment for breast cancer screening.</p>
<p><b>Cervical and vaginal cancer screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"><li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li><li>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months</li></ul>	<p>There is no copayment for cervical and vaginal cancer screening.</p>

Services that are covered for you	What you must pay when you get these services
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"><li>• Digital rectal exam</li><li>• Prostate Specific Antigen (PSA) test</li></ul>	<p>There is no copayment for prostate cancer screening exams.</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is copayment for cardiovascular disease testing.</p>
<p><b>“Welcome to Medicare” physical exam</b></p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p><b>Important:</b> You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” physical exam.</p>	<p>There is no copayment for the Welcome to Medicare exam.</p>
<p><b>Annual wellness visit</b></p> <p>If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p><b>Note:</b> Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” exam. However, you don’t need to have had a “Welcome to Medicare” exam to be covered for annual wellness visits after you’ve had Part B for 12 months.</p>	<p>There is no copayment for the annual wellness visit.</p>
<p><b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension),</p>	<p>There is no copayment for diabetes screening.</p>

Services that are covered for you	What you must pay when you get these services
<p>history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	
<p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician’s order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	<p>There is no copayment for medical nutrition therapy.</p>
<p><b>Smoking and tobacco use cessation (counseling to stop smoking)</b></p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p>If you haven’t been diagnosed with an illness caused or complicated by tobacco use:                      No copayment</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco:                      No copayment</p>
<p><b>Other Services</b></p>	
<p><b>Services to treat kidney disease and conditions</b></p>	<p>There is no copayment for</p>

Services that are covered for you	What you must pay when you get these services
<p>Covered services include:</p> <ul style="list-style-type: none"><li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li><li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li><li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li><li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li><li>• Home dialysis equipment and supplies</li><li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li></ul> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	<p>services to treat kidney disease and conditions.</p>
<p><b>Medicare Part B prescription drugs</b></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"><li>• Drugs that usually aren’t self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li><li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li><li>• Clotting factors you give yourself by injection if you have hemophilia</li><li>• Immunosuppressive drugs, if you were enrolled in Medicare</li></ul>	<p>There is no copayment for Medicare Part B prescription drugs.</p>

Services that are covered for you	What you must pay when you get these services
<p>Part A at the time of the organ transplant</p> <ul style="list-style-type: none"><li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</li><li>• Antigens</li><li>• Certain oral anti-cancer drugs and anti-nausea drugs</li><li>• 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)</li><li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li></ul> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	
<b>Additional Medicare Benefits</b>	
<p><b>Dental services*</b></p> <p>This section lists the dental benefits and services you are allowed to obtain through Partnership <i>Advantage</i> (HMO SNP), subject to the exclusions and limitations listed here and in the Exclusions section of this EOC (Chapter 4, Section 3).</p> <p>Covered services include:</p> <p><b>Covered Diagnostic and Preventative services</b></p> <ul style="list-style-type: none"><li>• Initial and periodic oral examinations</li><li>• Consultations, including specialist consultations</li><li>• Topical fluoride treatment</li><li>• Preventative dental education and oral hygiene instruction</li><li>• Roentgenology (x-rays)</li><li>• Prophylaxis services (cleanings)</li><li>• Dental sealant treatments</li></ul>	<p>There is no copayment for dental services.</p> <p>Some dental services require prior authorization.</p> <p>Dental services are offered through Delta Dental of California. You can call Delta at 877-580-1042.</p> <p>Delta Dental will send you a Delta Dental ID card with their contact information.</p> <p>You may qualify for additional dental benefits</p>

Services that are covered for you	What you must pay when you get these services
through Medi-Cal.	
<b>Diagnostic and Preventative services limitations</b>	
<ul style="list-style-type: none"><li>• Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in any 12 consecutive month period</li><li>• Isolated bitewing or periapical films are allowed on an emergency or episodic basis</li><li>• Full mouth x-rays in conjunction with periodic examinations are limited to once every 24 consecutive months</li><li>• Panoramic film x-rays are limited to once every 24 consecutive months</li><li>• Prophylaxis services (cleanings) are limited to two in an 12-month period</li><li>• Dental sealant treatments are limited to permanent first and second molars only and are limited to once every 24 consecutive months</li></ul>	
<b>Covered Restorative Dentistry</b>	
<ul style="list-style-type: none"><li>• Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries</li><li>• Micro filled resin restorations which are noncosmetic</li><li>• Replacement of restoration</li><li>• Use of pins and pin build-up in conjunction with a restoration</li><li>• Sedative base and sedative fillings</li></ul>	
<b>Restorative Dentistry limitations</b>	
<ul style="list-style-type: none"><li>• For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional</li><li>• Composite resin or acrylic restorations in posterior teeth are optional</li><li>• Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as a recurrent caries or fracture, and replacement is dentally necessary</li><li>• Amalgam and resin-based composite restorations are limited to</li></ul>	

Services that are covered for you	What you must pay when you get these services
once every 24 consecutive months	
<b>Covered Oral Surgery services</b>	
<ul style="list-style-type: none"><li>• Extractions, including surgical extractions</li><li>• Removal of impacted teeth</li><li>• Biopsy of oral tissues</li><li>• Alveolectomies</li><li>• Excision of cysts and neoplasms</li><li>• Treatment of palatal torus</li><li>• Treatment of mandibular torus</li><li>• Frenectomy</li><li>• Incision and drainage of abscesses</li><li>• Post-operative services, including exams, suture removal and treatment of complications</li><li>• Root recovery (separate procedure)</li></ul>	
<b>Oral Surgery limitation</b>	
<ul style="list-style-type: none"><li>• The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists</li></ul>	
<b>Covered Endodontic services</b>	
<ul style="list-style-type: none"><li>• Direct pulp capping</li><li>• Pulpotomy and vital pulpotomy</li><li>• Apexification filling with calcium hydroxide</li><li>• Root amputation</li><li>• Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below</li><li>• Apicoectomy</li><li>• Vitality tests</li></ul>	
<b>Endodontic services limitations</b>	
<ul style="list-style-type: none"><li>• Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms</li></ul>	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit</li></ul> <p><b>Covered Periodontic services</b></p> <ul style="list-style-type: none"><li>• Emergency treatment, including treatment for periodontal abscess and acute periodontitis</li><li>• Periodontal scaling and root planing, and subgingival curettage</li><li>• Gingivectomy</li><li>• Osseous or muco-gingival surgery</li></ul> <p><b>Periodontic services limitation</b></p> <ul style="list-style-type: none"><li>• Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months</li></ul> <p><b>Covered Crown and Fixed Bridge services</b></p> <ul style="list-style-type: none"><li>• Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel</li><li>• Related dowel pins and pin build-up</li><li>• Fixed bridges, which are case, porcelain baked with metal, or plastic processed to gold</li><li>• Recementation of crowns, bridges, inlays and onlays</li><li>• Cast prost and core, including cast retention under crowns</li><li>• Repair or replacement of crowns, abutments or pontics</li></ul> <p><b>Crown services limitations</b></p> <ul style="list-style-type: none"><li>• Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by the dental plan</li><li>• Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown</li></ul>	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling</li><li>• Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown</li></ul> <p><b>Fixed Bridge services limitations</b></p> <ul style="list-style-type: none"><li>• Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment</li><li>• A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 15, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in the cost between the fixed bridge and a space maintainer</li><li>• Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic</li><li>• Fixed bridges are optional when provided in connection with a partial denture on the same arch</li><li>• Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair</li><li>• The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth (6) unit, the treatment is considered full mouth reconstruction, which is optional treatment</li></ul> <p><b>Removal Prosthetics services</b></p> <ul style="list-style-type: none"><li>• Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers</li><li>• Office or laboratory relines or rebases</li><li>• Denture repair</li><li>• Denture adjustment</li></ul>	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"><li>• Tissue conditioning</li><li>• Denture duplication</li><li>• Space Maintainer</li><li>• Stayplates</li></ul> <p><b>Removal Prosthetics services limitations</b></p> <ul style="list-style-type: none"><li>• Partial dentures will not be replaced within 36 consecutive months, unless<ol style="list-style-type: none"><li>1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or</li><li>2. The denture is unsatisfactory and cannot be made satisfactory</li></ol></li><li>• The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch, the patient will be responsible for all additional charges.</li><li>• A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of dental arch. Other treatments of such cases are considered optional.</li><li>• Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.</li><li>• The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.</li><li>• Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.</li><li>• Tissue conditioning is limited to two (2) per denture</li><li>• Implants are considered an optional benefit</li></ul> <p><b>Other benefits</b></p>	

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>• Local anesthetics</li> <li>• Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure</li> <li>• Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure</li> <li>• Emergency treatment, palliative treatment</li> <li>• Coordination of benefits with member's health plan in the event a hospitalization or outpatient surgery setting is medically appropriate for dental services</li> </ul>	
<p><b>Hearing services</b></p> <p>Basic hearing evaluations performed by your PCP are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>There is no copayment for diagnostic hearing exams.</p>
<p><b>Non-Emergency Transportation*</b></p> <p>Non-emergency transportation to and from covered health care services.</p> <p>Transportation must be provided by a contracted transportation provider.</p> <p>Services are limited to a maximum cost of \$1,000.00 in a benefit year.</p> <p>Non-emergency transportation must be requested through the Member Services Department.</p>	<p>There is no-copayment for non-emergency transportation.</p> <p>This service requires prior authorization.</p>
<p><b>In-home Safety Assessment/Adaptation*</b></p> <p>Benefit includes assessment of the home for safety bars.</p> <p>Cost of the bar and installation are covered, if the assessor determines a need based on medical and/or physical condition.</p> <p>Benefit is limited to a total cost of \$1,000.00 per benefit year.</p>	<p>There is no copayment for In-home Safety Assessment/Adaptation.</p> <p>This service requires prior authorization.</p>

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## **SECTION 3      What benefits are not covered by the plan?**

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<b>Section 3.1      Benefits <i>not</i> covered by the plan (exclusions)</b>
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This section tells you what kinds of benefits are “excluded”. Excluded means that the plan doesn’t cover these benefits. In some cases, we cover items or services that are excluded by Medicare under our plan’s Medi-Cal (Medicaid) benefits. For more information about Medi-Cal benefits, call Member Services (phone numbers are on the back cover of this booklet).

The list below describes some services and items that aren’t covered by the plan under any conditions and some that are excluded by the plan only under specific conditions. The list also tells you if the service or item is covered by the plan under Medi-Cal.

We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare or Medi-Cal. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Evidence of Coverage*, **the following items and services aren’t covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.

- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines. **You may be eligible for additional chiropractic care under Medi-Cal.**
- Routine foot care, except for the limited coverage provided according to Medicare guidelines. **You may be eligible for additional routine foot care under Medi-Cal.**
- 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.
- Routine hearing exams, hearing aids, or exams to fit hearing aids. **You may be eligible for hearing exams, hearing aids or exams to fit hearing aids under Medi-Cal.**
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, eyeglasses are covered for people as specified in the benefit chart.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture. **You may be eligible for acupuncture benefits under Medi-Cal.**
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

### **Excluded Dental Services**

The following dental services are excluded from our plan:

- Any service that is not specifically listed as a covered benefit in this booklet (see Chapter 4).

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- Any service listed as a covered benefit in this booklet that has met the frequency limitation.
  - Dental services of any kind (other than emergency care or pre-authorized dental services performed by a specialist to whom the patient has been referred) performed by a non-network dentist.
  - Any services not determined to be necessary or appropriate.

### **Non-Covered Dental Services**

The Dental Program does not cover: dental services that are received from a non-Network Dentist; items listed in the Exclusion Section or dental services that exceed the frequency limitations. You will be responsible for all charges related to these services if you agree to have them.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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## **Chapter 5. Using the plan's coverage for your Part D prescription drugs**

<b>SECTION 1</b>	<b>Introduction</b> .....	<b>76</b>
Section 1.1	This chapter describes your coverage for Part D drugs .....	76
Section 1.2	Basic rules for the plan's Part D drug coverage .....	77
<b>SECTION 2</b>	<b>Your prescriptions should be written by a network provider</b> .....	<b>77</b>
Section 2.1	In most cases, your prescription must be from a network provider.....	77
<b>SECTION 3</b>	<b>Fill your prescription at a network pharmacy or through the plan's mail-order service</b> .....	<b>78</b>
Section 3.1	To have your prescription covered, use a network pharmacy .....	78
Section 3.2	Finding network pharmacies.....	78
Section 3.3	Using the plan's mail-order services.....	79
Section 3.4	How can you get a long-term supply of drugs? .....	79
Section 3.5	When can you use a pharmacy that is not in the plan's network? .....	80
<b>SECTION 4</b>	<b>Your drugs need to be on the plan's "Formulary"</b> .....	<b>80</b>
Section 4.1	The "Formulary" tells which Part D drugs are covered.....	80
Section 4.2	There are two (2) "cost-sharing tiers" for drugs on the Formulary .....	81
Section 4.3	How can you find out if a specific drug is on the Formulary? .....	82
<b>SECTION 5</b>	<b>There are restrictions on coverage for some drugs</b> .....	<b>82</b>
Section 5.1	Why do some drugs have restrictions? .....	82
Section 5.2	What kinds of restrictions? .....	82
Section 5.3	Do any of these restrictions apply to your drugs?.....	83

---

<b>SECTION 6</b>	<b>What if one of your drugs is not covered in the way you'd like it to be covered? .....</b>	<b>84</b>
Section 6.1	There are things you can do if your drug is not covered in the way you'd like it to be covered .....	84
Section 6.2	What can you do if your drug is not on the Formulary or if the drug is restricted in some way?.....	84
Section 6.3	What can you do if your drug is in a cost-sharing tier you think is too high?.....	87
<b>SECTION 7</b>	<b>What if your coverage changes for one of your drugs?.....</b>	<b>88</b>
Section 7.1	The Formulary can change during the year .....	88
Section 7.2	What happens if coverage changes for a drug you are taking?.....	89
<b>SECTION 8</b>	<b>What types of drugs are <i>not</i> covered by the plan?.....</b>	<b>90</b>
Section 8.1	Types of drugs we do not cover .....	90
<b>SECTION 9</b>	<b>Show your plan membership card when you fill a prescription .....</b>	<b>91</b>
Section 9.1	Show your membership card .....	91
Section 9.2	What if you don't have your membership card with you?.....	91
<b>SECTION 10</b>	<b>Part D drug coverage in special situations.....</b>	<b>91</b>
Section 10.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?.....	91
Section 10.2	What if you're a resident in a long-term care facility? .....	91
Section 10.3	What if you're also getting drug coverage from an employer or retiree group plan?.....	92
<b>SECTION 11</b>	<b>Programs on drug safety and managing medications.....</b>	<b>93</b>
Section 11.1	Programs to help members use drugs safely.....	93
Section 11.2	Programs to help members manage their medications .....	93



### **How can you get information about your drug costs?**

Because you are eligible for Medi-Cal (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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## **SECTION 1 Introduction**

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<b>Section 1.1 This chapter describes your coverage for Part D drugs</b>
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This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, Partnership *Advantage* also covers some drugs under the plan’s medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Benefits Chart, what is covered*) tells about the benefits for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Benefits Chart, what is covered*) tells about the coverage for Part B drugs.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medi-Cal (Medicaid) benefits. PHC has a separate formulary for your Medi-Cal benefits. If you need a copy of this document, or have questions about your Medi-Cal drug benefits you can call Member Services (phone numbers are on the back cover of this booklet).

**This chapter explains rules for using your coverage for Medicare Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

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<b>Section 1.2</b>	<b>Basic rules for the plan's Part D drug coverage</b>
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a network provider (a doctor or other prescriber) write your prescription. (For more information, see Section 2, *Your prescriptions should be written by a network provider.*)
- You must use a network pharmacy to fill your prescription. (See Section 3, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Formulary" for short). (See Section 4, *Your drugs need to be on the plan's "Formulary."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

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<b>SECTION 2</b>	<b>Your prescriptions should be written by a network provider</b>
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<b>Section 2.1</b>	<b>In most cases, your prescription must be from a network provider</b>
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You need to get your prescription (as well as your other care) from a provider in the plan's provider network. This person would often be your primary care provider (your PCP). It could also be another professional in our provider network if your PCP has referred you for care.

To find network providers, look in the *Provider Directory*.

**The plan will cover prescriptions from providers who are not in the plan's network only in a few special circumstances.** These include:

- Prescriptions you get in connection with covered emergency care.
- Prescriptions you get in connection with covered urgently needed care when network providers are not available.

Other than these circumstances, you must have approval in advance ("prior authorization") from the plan to get coverage of a prescription from an out-of-network provider.

If you pay "out-of-pocket" for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Member Services or send the bill to us for payment. Chapter 7, Section 2.1 tells how to ask us to pay our share of the cost for the drug.

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## **SECTION 3      Fill your prescription at a network pharmacy or through the plan's mail-order service**

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<b>Section 3.1      To have your prescription covered, use a network pharmacy</b>
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In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Formulary.

<b>Section 3.2      Finding network pharmacies</b>
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### **How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Provider Directory*, visit our website ([www.partnershiphp.org](http://www.partnershiphp.org)), or call Member Services (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

### **What if the pharmacy you have been using leaves the network?**

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the back cover of this booklet) or use the *Provider Directory*. You can also find information on our website at [www.partnershiphp.org](http://www.partnershiphp.org).

### **What if you need 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. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our

network. If your long-term care pharmacy is not in our network, please contact Member Services.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- 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 locate a specialized pharmacy, look in your *Provider Directory* or call Member Services.

### **Section 3.3 Using the plan's mail-order services**

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our plan's mail-order service are marked as "**maintenance**" drugs in our Formulary.

Our plan's mail-order service requires you to order a **90-day supply of the drug**.

To get information about filling your prescriptions by mail contact Member Services. If you use a mail-order pharmacy that is not in the plan's network, your prescription will not be covered. Our mail-house pharmacy is listed in the *Provider Directory*.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your current supply is low, please contact Member Services for help getting your prescription at a retail pharmacy in our network.

### **Section 3.4 How can you get a long-term supply of drugs?**

When you get a long-term supply of drugs, your cost sharing may be lower.] The plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's Formulary. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies agree to accept the mail-order cost-sharing amount for a long-term supply of mail-order drugs. Your *Provider Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. The drugs available through our plan's mail-order service are marked as "**maintenance**" drugs in our Formulary. Our plan's mail-order service requires you to order a 90-day

supply of the drug. See Section 3.3 for more information about using our mail-order services.

<b>Section 3.5</b>	<b>When can you use a pharmacy that is not in the plan's network?</b>
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### Your prescription may be covered in certain situations

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

- If you are unable to access an in-network pharmacy, you may be able to receive your medications at an out-of-network pharmacy at the in-network copayment amount.
- For Generic drugs, there is a \$0 copayment throughout the benefit year. For Brand drugs, there is a \$0, \$3.30 or \$6.50 copayment depending on your level of Medi-Cal eligibility. If you enter the Catastrophic Coverage Stage you will receive both Generic and Brand drugs, out-of-network at a \$0 copayment.
- Your prescription at an out-of-network pharmacy is limited to 29-days. If you need to obtain a longer supply of prescription medications, you will need to receive the medication from an in-network pharmacy.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

### How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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## **SECTION 4**      **Your drugs need to be on the plan's "Formulary"**

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<b>Section 4.1</b>	<b>The "Formulary" tells which Part D drugs are covered</b>
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The plan has a "*List of Covered Drugs (Formulary)*." In this *Evidence of Coverage*, **we call it the "Formulary" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Formulary.

We will generally cover a drug on the plan's Formulary as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

### **The Formulary includes both brand name and generic drugs**

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

### **What is *not* on the Formulary?**

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Formulary.
- Your Medi-Cal covered drugs are detailed in the Medi-Cal formulary. Call Member Services for a copy of the Medi-Cal formulary or to learn more about your Medi-Cal drug coverage.

<b>Section 4.2</b>	<b>There are two (2) "cost-sharing tiers" for drugs on the Formulary</b>
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Every drug on the plan's Formulary is in one of two (2) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier one is called the Generic tier, which contains all Generic drugs. This is the lowest cost tier, meaning the lowest cost drugs to you are in this tier. All drugs in this list may be obtained at a \$0 copayment throughout the benefit year.
- Tier two is called the Brand tier, which contains all Brand drugs, and Brand drugs treated as Generic. This is the higher cost tier. Brand drugs can be obtained at a \$0, \$3.30 or \$6.50 copayment depending on your level of Medi-Cal eligibility. If you reach the Catastrophic Coverage Stage you may obtain a Brand drug at a \$0 copayment.

To find out which cost-sharing tier your drug is in, look it up in the plan's Formulary.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

### **Section 4.3      How can you find out if a specific drug is on the Formulary?**

You have three (3) ways to find out:

1. Check the most recent Formulary we sent you in the mail.
2. Visit the plan's website ([www.partnershiphp.org](http://www.partnershiphp.org)). The Formulary on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Formulary or to ask for a copy of the list. Phone numbers for Member Services are on the back cover of this booklet.

## **SECTION 5      There are restrictions on coverage for some drugs**

### **Section 5.1      Why do some drugs have restrictions?**

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

### **Section 5.2      What kinds of restrictions?**

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

## Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you or has written “No substitutions” on your prescription for a brand name drug or has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

## Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

## Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called “**step therapy.**”

## Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

<b>Section 5.3</b>	<b>Do any of these restrictions apply to your drugs?</b>
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The plan’s Formulary includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Formulary. For the most up-to-date information, call Member Services (phone numbers are on the back cover of this booklet) or check our website ([www.partnershiphp.org](http://www.partnershiphp.org)).

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not

agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

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## **SECTION 6      What if one of your drugs is not covered in the way you'd like it to be covered?**

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<b>Section 6.1      There are things you can do if your drug is not covered in the way you'd like it to be covered</b>
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Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of two (2) different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Formulary or if your drug is restricted, go to Section 6.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

<b>Section 6.2      What can you do if your drug is not on the Formulary or if the drug is restricted in some way?</b>
--

If your drug is not on the Formulary or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

### **You may be able to get a temporary supply**

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Formulary or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

#### **1. The change to your drug coverage must be one of the following types of changes:**

- The drug you have been taking is **no longer on the plan's Formulary**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 5 in this chapter tells about restrictions).

#### **2. You must be in one of the situations described below:**

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31 day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

### **Our Transition Policy**

- New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Chapter 9, Section 7 under "What is an exception?" to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.
- During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first must be at least 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year OR provide you with the opportunity to request a formulary exception in advance for the following year.
- When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover up to a 90-day supply (unless the prescription is written for fewer days). After we cover the temporary supply (up to 90 days), we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.
- If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition

policy can't be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access. See Chapter 5, Section 4 for information about non-Part D drugs.

To ask for a temporary supply, call Member Services (phone numbers are on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

### **You can change to another drug**

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### **You can ask for an exception**

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Formulary. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow a transition process that is consistent with a new member enrollee.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

<b>Section 6.3</b>	<b>What can you do if your drug is in a cost-sharing tier you think is too high?</b>
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

### **You can change to another drug**

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you.

You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### **You can ask for an exception**

For drugs in the brand tier, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in the generic tier.

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## **SECTION 7      What if your coverage changes for one of your drugs?**

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<b>Section 7.1      The Formulary can change during the year</b>
--

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Formulary. For example, the plan might:

- **Add or remove drugs from the Formulary.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Formulary.

## Section 7.2 What happens if coverage changes for a drug you are taking?

### How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Formulary. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

### Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Formulary, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Formulary. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

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## **SECTION 8      What types of drugs are *not* covered by the plan?**

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<b>Section 8.1      Types of drugs we do not cover</b>
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug excluded by our plan is also excluded by Medi-Cal (Medicaid), you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare. However, some of these drugs may be covered for you under your Medi-Cal drug coverage. You can find out which drugs are covered under Medi-Cal by checking your Medi-Cal formulary or calling Member Services.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain

- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

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## **SECTION 9      Show your plan membership card when you fill a prescription**

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<b>Section 9.1      Show your membership card</b>
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To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for our share of the costs of your covered prescription drug. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

<b>Section 9.2      What if you don't have your membership card with you?</b>
---

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

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## **SECTION 10      Part D drug coverage in special situations**

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<b>Section 10.1      What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?</b>
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

<b>Section 10.2      What if you're a resident in a long-term care facility?</b>
--

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you

may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

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

### **What if you're a resident in a long-term care facility and become a new member of the plan?**

If you need a drug that is not on our Formulary or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Formulary or if the plan has any restriction on the drug's coverage, we will cover one 31 day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

<b>Section 10.3</b>	<b>What if you're also getting drug coverage from an employer or retiree group plan?</b>
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

#### **Special note about 'creditable coverage':**

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

**Keep these notices about creditable coverage**, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

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## **SECTION 11      Programs on drug safety and managing medications**

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<b>Section 11.1      Programs to help members use drugs safely</b>
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

<b>Section 11.2      Programs to help members manage their medications</b>
--

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw

you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back cover of this booklet).

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## **Chapter 6. What you pay for your Part D prescription drugs**

<b>SECTION 1</b>	<b>Introduction.....</b>	<b>97</b>
Section 1.1	Use this chapter together with other materials that explain your drug coverage .....	97
<b>SECTION 2</b>	<b>What you pay for a drug depends on which “drug payment stage” you are in when you get the drug .....</b>	<b>99</b>
Section 2.1	What are the drug payment stages for Partnership <i>Advantage</i> members?.....	99
<b>SECTION 3</b>	<b>We send you reports that explain payments for your drugs and which payment stage you are in.....</b>	<b>101</b>
Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”).....	101
Section 3.2	Help us keep our information about your drug payments up to date.....	101
<b>SECTION 4</b>	<b>During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share .....</b>	<b>102</b>
Section 4.1	What you pay for a drug depends on the drug and where you fill your prescription .....	102
Section 4.2	A table that shows your costs for a one-month supply of a drug.....	103
Section 4.3	A table that shows your costs for a long-term (insert if applicable: up to a 90-day) supply of a drug .....	104
Section 4.4	You stay in the Initial Coverage Stage until total drug costs for the year reach \$2,100.00.....	105
<b>SECTION 5</b>	<b>During the Coverage Gap Stage, the plan provides some drug coverage .....</b>	<b>105</b>
Section 5.1	You stay in the Coverage Gap Stage until your total drug costs for the year reach \$4,700.00 (after the \$2,100.00 Initial Coverage Stage) .....	105
Section 5.2	How Medicare calculates your out-of-pocket costs for prescription drugs.....	105

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**SECTION 6 During the Catastrophic Coverage Stage, the plan pays all of the costs for your drugs ..... 108**

Section 6.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year .....108

**SECTION 7 What you pay for vaccinations covered by Part D depends on how and where you get them ..... 108**

Section 7.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot .....108

Section 7.2 You may want to call us at Member Services before you get a vaccination .....110



## How can you get information about your drug costs?

Because you are eligible for Medi-Cal (Medicaid), you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>Use this chapter together with other materials that explain your drug coverage</b>
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This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medi-Cal.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Formulary.”
  - This Formulary tells which drugs are covered for you.
  - It also tells which of the two (2) “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Formulary, call Member Services (phone numbers are on the back cover of this booklet). You can also find the Formulary on our website at [www.partnershiphp.org](http://www.partnershiphp.org). The Formulary on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s *Provider Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Provider Directory has a list of

pharmacies in the plan's network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month's supply).

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**SECTION 2      What you pay for a drug depends on which “drug payment stage” you are in when you get the drug**

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<b>Section 2.1      What are the drug payment stages for Partnership <i>Advantage</i> members?</b>
--

As shown in the table below, there are “drug payment stages” for your Medicare Part D prescription drug coverage under Partnership *Advantage*. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

<p><b>Stage 1</b> <i>Yearly Deductible Stage</i></p>	<p><b>Stage 2</b> <i>Initial Coverage Stage</i></p>	<p><b>Stage 3</b> <i>Coverage Gap Stage</i></p>	<p><b>Stage 4</b> <i>Catastrophic Coverage Stage</i></p>
<p>Because there is no deductible for the plan, this payment stage does not apply to you.</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b></p> <p>You stay in this stage until your year-to-date <b>“total drug costs”</b> reach a total of \$2,100.00.</p> <p>You pay \$0 for each generic prescription.</p> <p>You pay either \$0, \$3.30 or \$6.50 for each brand prescription depending on your level of Medi-Cal eligibility.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>You pay \$0 for each generic prescription.</p> <p>You pay either \$0, \$3.30 or \$6.50 for each brand prescription depending on your level of Medi-Cal eligibility.</p> <p>You stay in this stage until your year-to-date <b>“total drug costs”</b> reach a total of \$6,800.00 (\$4,700.00 plus the \$2,100.00 Initial Coverage limit). This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, <b>the plan will pay all of the costs</b> of your drugs for the rest of the calendar year (through December 31, 2012).</p> <p>You pay no copayments for all covered drugs.</p> <p>(Details are in Section 7 of this chapter.)</p>

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## **SECTION 3      We send you reports that explain payments for your drugs and which payment stage you are in**

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<b>Section 3.1      We send you a monthly report called the “Explanation of Benefits” (the “EOB”)</b>
---

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

<b>Section 3.2      Help us keep our information about your drug payments up to date</b>
--

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your total drug costs. To help us keep track of your total drug costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:

- When you purchase 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 made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your total drug costs and help qualify you for catastrophic coverage. For example, covered drugs purchased by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your total drug costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

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## **SECTION 4      During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share**

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<b>Section 4.1      What you pay for a drug depends on the drug and where you fill your prescription</b>
--

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment). Your share of the cost will vary depending on the drug and where you fill your prescription.

### **The plan has two (2) cost-sharing tiers**

Every drug on the plan's Formulary is in one of two (2) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-sharing tier 1 is the generic drug tier. This is the lowest cost tier. You pay \$0 copayments for drugs in this tier.
- Cost-sharing tier 2 is the brand drug tier. This is the highest cost tier. You pay either \$0, \$3.30 or \$6.50 for drugs in this tier, depending on your level of Medi-Cal eligibility.

To find out which cost-sharing tier your drug is in, look it up in the plan's Formulary.

## Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Provider Directory*.

<b>Section 4.2</b>	<b>A table that shows your costs for a one-month supply of a drug</b>
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During the Initial Coverage Stage, your share of the cost of a covered drug will be a copayment.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of the copayment depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 3.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

**Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:**

	<b>Network pharmacy</b>	<b>The plan's mail-order service</b>	<b>Network long-term care pharmacy</b>	<b>Out-of-network pharmacy</b> (Coverage is limited to certain situations; see Chapter 5 for details.)
<b>Cost-Sharing Tier 1</b> (generic drugs)	\$0	\$0	\$0	\$0
<b>Cost-Sharing Tier 2</b> (brand drugs)	\$0, \$3.30 or \$6.50	\$0, \$3.30 or \$6.50	\$0, \$3.30 or \$6.50	\$0, \$3.30 or \$6.50

**Section 4.3 A table that shows your costs for a *long-term* (up to a 90-day) 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 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

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

	<b>Network pharmacy</b> (up to a 90-day supply)	<b>The plan's mail-order service</b> (up to a 90-day supply)
<b>Cost-Sharing Tier 1</b> (generic drugs)	\$0	\$0
<b>Cost-Sharing Tier 2</b> (brand drugs)	\$0, \$3.30 or \$6.50	\$0, \$3.30 or \$6.50

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<b>Section 4.4</b>	<b>You stay in the Initial Coverage Stage total drug costs for the year reach \$2100.00</b>
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$2,100.00 limit for the Initial Coverage Stage**.

Your total drug cost is based on what any Part D plan has paid:

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit. We also provide some over-the-counter medications exclusively for your use. These over-the-counter drugs are provided at no cost to you. To find out which drugs our plan covers, refer to your formulary. Section 4.5 tells you more about what counts toward your total drug costs.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much the plan has spent for your drugs during the year. Many people do not reach the \$2,100.00 limit in a year.

We will let you know if you reach this \$2,100.00 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

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<b>SECTION 5</b>	<b>During the Coverage Gap Stage, the plan provides some drug coverage</b>
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<b>Section 5.1</b>	<b>You stay in the Coverage Gap Stage until your total drug costs reach \$6,800.00</b>
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When you are in the Coverage Gap Stage, you pay \$0 for generic drugs and \$0, \$3.30 or \$6.50 for brand drugs. Your total drug costs move you through the Coverage Gap. Medicare has rules about what counts and what does *not* count towards your total drug costs.

The Coverage Gap in 2012 is \$4,700.00 in total drug costs. This amount, plus the \$2,100.00 Initial Coverage Stage limit mean you must have \$6,800.00 in total drug costs in a year to move to the Catastrophic Drug Stage.

<b>Section 5.2</b>	<b>How Medicare calculates your total drug costs for prescription drugs</b>
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Here are Medicare's rules that we must follow when we keep track of your total drug costs for your drugs.

*These payments **are included** in your total drug costs*

*When you add up your total drug costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount your drugs cost when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
  - The Coverage Gap Stage.
- Any drug costs paid during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

**It matters who pays:**

- If you make these payments **yourself**, they are included in your total drug costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

***Moving on to the Catastrophic Coverage Stage:***

*When your total drug costs reach \$6,800.00 in the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.*

*These payments are **not included** in your total drug costs*

When you add up your total drug costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- *Drugs you buy outside the United States and its territories.*
- *Drugs that are not covered by our plan.*
- *Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.*
- *Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.*
- *Drugs that are paid for by your Medi-Cal coverage*
- *Payments for your drugs that are made by group health plans including employer health plans.*
- *Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.*
- *Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).*

*Reminder:* If any other organization such as the ones listed above pays part or all of your total drug costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the back cover of this booklet).

### ***How can you keep track of your total drug costs?***

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your total drug costs (Section 3 in this chapter tells about this report). When you reach a total of \$6,800.00 in total drug costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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## **SECTION 6      During the Catastrophic Coverage Stage, the plan pays all of the costs for your drugs**

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<b>Section 6.1</b>	<b>Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year</b>
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You qualify for the Catastrophic Coverage Stage when your total drug costs have reached the \$6,700.00 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay all of the costs for your drugs.

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## **SECTION 7      What you pay for vaccinations covered by Part D depends on how and where you get them**

---

<b>Section 7.1</b>	<b>Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot</b>
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Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Benefits Chart in Chapter 4, Section 2.1.

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

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

### **What do you pay for a Part D vaccination?**

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Benefits Chart (what is covered)*.
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine medication.**

### 3. Who gives you the vaccination shot.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot.

*Situation 1:* You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

*Situation 2:* You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay you back for our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

*Situation 3:* You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay you back for our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

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<b>Section 7.2</b>	<b>You may want to call us at Member Services before you get a vaccination</b>
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to ask us to pay you back for our share of the cost.

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## **Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**

<b>SECTION 1</b>	<b>Situations in which you should ask us to pay for your covered services or drugs .....</b>	<b>112</b>
Section 1.1	If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment.....	112
<b>SECTION 2</b>	<b>How to ask us to pay you back or to pay a bill you have received .....</b>	<b>114</b>
Section 2.1	How and where to send us your request for payment.....	114
<b>SECTION 3</b>	<b>We will consider your request for payment and say yes or no .....</b>	<b>115</b>
Section 3.1	We check to see whether we should cover the service or drug and how much we owe .....	115
Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal.....	115
<b>SECTION 4</b>	<b>Other situations in which you should save your receipts and send copies to us.....</b>	<b>116</b>
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your total drug drug costs .....	116

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**SECTION 1      Situations in which you should ask us to pay for your covered services or drugs**

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<b>Section 1.1      If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment</b>
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for the full cost of medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

**1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network**

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost for the service, we will determine how much you owed and pay you back for our share of the cost.

## **2. When a network provider sends you a bill you think you should not pay**

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay more than your share of the cost.

- 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 resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for the difference between the amount you paid and the amount you owed under the plan.

## **3. If you are retroactively enrolled in our plan.**

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 3.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

## **5. When you pay the full cost for a prescription because you don't have your plan membership card with you**

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

## 6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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## **SECTION 2      How to ask us to pay you back or to pay a bill you have received**

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<b>Section 2.1      How and where to send us your request for payment</b>
---

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Call Member Services and ask for the form. The phone numbers for Member Services are on the back cover of this booklet. This form is only for Part D requests.

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

Partnership HealthPlan of California  
Attention: Member Services Department  
360 Campus Lane, Suite 100  
Fairfield, CA 94534

**You must submit your claim to us within 15 days** of the date you received the service, item, or drug. We generally require that providers bill us for services and reimburse you directly for medical services.

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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## **SECTION 3      We will consider your request for payment and say yes or no**

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<b>Section 3.1      We check to see whether we should cover the service or drug and how much we owe</b>
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost of the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

<b>Section 3.2      If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal</b>
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives

definitions of terms such as “appeal.” Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

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## **SECTION 4      Other situations in which you should save your receipts and send copies to us**

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<b>Section 4.1      In some cases, you should send copies of your receipts to us to help us track your total drug costs</b>
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your total drug costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

### **When you get a drug through a patient assistance program offered by a drug manufacturer**

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your total drug expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan’s benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your total drug costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

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## **Chapter 8. Your rights and responsibilities**

<b>SECTION 1</b>	<b>Our plan must honor your rights as a member of the plan.....</b>	<b>118</b>
Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.).....	118
Section 1.2	We must treat you with fairness and respect at all times .....	119
Section 1.3	We must ensure that you get timely access to your covered services and drugs.....	119
Section 1.4	We must protect the privacy of your personal health information .....	119
Section 1.5	We must give you information about the plan, its network of providers, and your covered services .....	129
Section 1.6	We must support your right to make decisions about your care.....	130
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made.....	132
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?.....	133
Section 1.9	How to get more information about your rights .....	133
<b>SECTION 2</b>	<b>You have some responsibilities as a member of the plan .....</b>	<b>134</b>
Section 2.1	What are your responsibilities?.....	134

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## **SECTION 1      Our plan must honor your rights as a member of the plan**

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<b>Section 1.1</b>	<b>We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)</b>
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<b>Sección 1.1</b>	<b>Debemos proporcionar la información de una manera que funcione para usted (en idiomas distintos al inglés, en Braille, en letra grande y otros formatos alternativos, etc.)</b>
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To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. All of our materials, including this EOC are available in our plan's threshold language: Spanish. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Para obtener información de nosotros en una forma que funcione para usted, llame a Servicios al Miembro (los números de teléfono aparecen en la contraportada de este folleto).

Nuestro plan tiene disponibles personas y servicios de intérpretes de otros idiomas sin costo para responder a las preguntas de los miembros que no hablan inglés. Todos nuestros materiales, incluyendo esta EOC, están disponibles en el idioma más común de nuestro plan: español. También le podemos dar información en Braille, en letra grande y en otros formatos alternativos si lo necesita. Si usted es elegible para Medicare debido a una discapacidad, estamos obligados a proporcionarle información sobre los beneficios del plan que sean accesibles y adecuados para usted.

Si tiene dificultades para obtener información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los siete días de la semana, y dígalos que desea presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

**Section 1.2 We must treat you with fairness and respect at all times**

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

**Section 1.3 We must ensure that you get timely access to your covered services and drugs**

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

**Section 1.4 We must protect the privacy of your personal health information**

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

### **How do we protect the privacy of your health information?**

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

### **You can see the information in your records and know how it has been shared with others**

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the back cover of this booklet).

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## **Partnership HealthPlan of California's Notice of Privacy Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

### *Why am I receiving this Notice?*

Partnership HealthPlan of California (PHC) is required by law to maintain the privacy of your health information. We are required to inform you of our legal duties and privacy practices where your protected health information (PHI) is concerned.

We agree to follow the terms of this Notice of Privacy Practices. We also have the right to change the terms of this notice if it becomes necessary, and to make the new notice effective for all health information we maintain. If we need to make any changes, we will provide you an updated copy of this notice by mailing it to you at your address in our records. If you received this notice electronically, you have the right to request a paper copy from us at any time.

### *How does Partnership HealthPlan of California use and disclose my health information?*

PHC stores health-related records about you, including your claims history, health plan enrollment information, case management records, and prior authorizations for health services. We use this information and disclose it to others for the following purposes:

***Treatment.*** PHC uses your health information to coordinate your health care, and we disclose it to hospitals, clinics, physicians and other health care providers to enable them to provide health care services to you. For example, PHC maintains your health information in electronic form, and allows health care providers to have on-line access to it to provide treatment to you.

***Payment.*** PHC uses and discloses your health information to make payment for health care services you receive, including determining your eligibility for benefits, and your provider's eligibility for payment. For example, we inform providers that you are a member of our plan, and tell them your eligible benefits.

***Health care operations.*** PHC uses and discloses your health information as necessary to enable us to operate our health plan. For example, we use our members' claims information for our internal financial accounting activities, and for quality assurance purposes.

We also disclose health information to our contractors and agents who assist us in these functions, but we obtain a confidentiality agreement from them before we make such disclosures for payment or operational purposes. For example, companies that provide or maintain our computer services may have access to computerized health information in the course of providing services to us.

***Why are we contacting you?***

We may contact you to provide appointment reminders or information about treatment options available to you. We may also contact you about other health-related services that may interest you.

***Can others involved in my care receive information about me?***

Yes, we may release medical information to a friend or family member who is involved in your care, or whose paying for your care, to the extent we judge it necessary for their participation. This includes responding to telephone enquiries about eligibility and claim status.

***Can my health information ever be released without my permission?***

Yes, we may disclose health information without your authorization to government agencies and private individuals and organizations in a variety of circumstances in which we are required or authorized by law to do so. Here are the general kinds of disclosures we may be required or allowed to make without your authorization:

- Disclosures that are required by state or federal law
- Disclosures to public health authorities or to other persons in connection with public health activities
- To government agencies authorized to receive reports of abuse or neglect of children or dependent adults, or domestic violence
- To agencies responsible for overseeing the health care system, for audits, inspections or investigations
- For judicial and administrative proceedings, such as lawsuits
- To law enforcement agencies
- To coroners and medical examiners
- To organ procurement agencies, if you are an organ donor or a possible donor
- To researchers conducting research under the auspices of an Institutional Review Board or privacy board
- To avert a serious threat to health or safety
- To assist authorized federal officials in national security activities, or for the provision of protective services to officials
- If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the institution or official
- To other agencies administering government health benefit programs, as authorized or required by law
- To comply with workers' compensation laws.

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***Are there instances when my PHI is not released?***

Your health information may be subject to restrictions that may limit or prevent some uses or disclosures. For example, there are special restrictions on the disclosure of health information relating to HIV/AIDS status, mental health treatment, developmental disabilities, and drug and alcohol abuse treatment. We comply with these restrictions in our use of your health information.

We will not permit other uses and disclosures of your health information without your written permission, or authorization which you may revoke at any time in the manner described in our authorization form.

**Your Individual Rights**

***What rights do I have as a PHC member?***

As a PHC member you have the following rights:

- You have the right to ask us to restrict certain uses and disclosures of your health information. However, PHC is not required to agree to any restrictions requested by its members.
- To protect your privacy, you have the right to receive confidential communications from PHC at a particular phone number, P.O. Box, or some other address that you specify to us.
- You have the right to see and copy any of your health records that PHC maintains on you. We must receive your request in writing. We will respond to your request within 30 days. If your records are stored in another location, please allow 60 days for us to respond to your request. We may charge a fee to cover the cost of copying your records. Under certain circumstances, PHC may deny your request. If your request is denied, we will tell you the reason why in writing. You have the right to appeal the denial.
- If you feel the information in our records is wrong, you have the right to request us to amend the records. We may deny your request in certain circumstances. If your request is denied, you have the right to submit a statement for inclusion in the record.
- You have the right to receive a report of non-routine disclosures that we have made of your health information, up to six years prior from the date of your request (but not earlier than April 14, 2003). There are some exceptions: for example, we do not maintain records of disclosures made with your authorization; disclosures made for the purposes of health care treatment, determining payment for health services, or conducting the health plan operations of PHC; disclosures made to you; and certain other disclosures.
- If you received this notice electronically, you have the right to request a paper copy from us at any time.

***How do I exercise these rights?***

You can exercise any of your rights by sending a written request to our Privacy Official at the address below. To facilitate processing of your request, we encourage you to use our request

form, which you can obtain from our Internet site at [www.partnershiphp.org](http://www.partnershiphp.org) or by calling us at the telephone number below. You can also obtain a complete statement of your rights, including our procedures for responding to requests to exercise your rights, by calling or writing to the Privacy Official at the address below.

***How do I file a complaint if my privacy rights are violated?***

As a PHC member, you have the right to file a complaint with our Privacy Official. You must provide us with specific, written information to support your complaint. You may also file a complaint with the Secretary of Health and Human Services.

PHC will not retaliate against you in any way for filing a complaint. Filing a complaint will not adversely affect the quality health care services you receive as a PHC member.

***Contact us at:***

Privacy Official: Partnership Health Plan of California  
Mailing address: 360 Campus Lane, Ste 100  
Fairfield, CA 94534  
Telephone Number: 1-800-863-4155 or  
TTY/TDD 1-800-735-2929 or call 711  
PHC's Hot-Line is 1-800-601-2146 and is operated 24 hours a day and 7 days a week

***Contact the California's Department of Health Care Services:***

DHCS Privacy Officer  
c/o Office of Legal Services  
Ca Dept. of Health Care Services  
PO Box 997413, MS 0011  
Sacramento, CA 95899-7413  
PH: 916-440-7750  
Privacyofficer@dhcs.ca.gov  
TTY/TDD 877-735-2929  
Fax 916-440-7680

***Contact the Secretary of United States Departments of Health and Human Services at:***

Office for Civil Rights  
Attn: Regional Manager  
U.S. Department of Health and Human Services  
90 7th Street, Suite 4-100  
San Francisco, CA 94103  
Voice Phone 415-437-8310  
FAX 415-437-8329  
TDD 415-437-8311

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## **Delta Dental Privacy Practices**

Delta Dental is prohibited by law from disclosing a member's medical or dental information without the member's authorization. However, there are some important exceptions to this law that allow plans to disclose member information, such as the purposes of diagnosis or treatment, billing, or peer review committees.

Delta Dental's Notice of Privacy Practices regarding their policies and procedures for preserving the confidentiality of medical records is attached for your reference.

### **Delta Dental Notice of Privacy Practices: Confidentiality of your health care information**

**This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information.**

**Please Review It Carefully.**

This notice is required by law to tell you how Delta Dental of California and its affiliates ("Delta Dental") protect the confidentiality of your health care information in our possession. Protected Health Information (PHI) is defined as any individually identifiable information regarding a patient's health care history; mental or physical condition; or treatment. Some examples of PHI include your name, address, telephone and/or fax number, electronic mail address, social security number or other identification number, date of birth, date of treatment, treatment records, x-rays, enrollment and claims records. Delta Dental receives, uses and discloses your PHI to administer your benefit plan or as permitted or required by law. Any other disclosure of your PHI without your authorization is prohibited.

Delta Dental must follow the privacy practices that are described in this notice, but also comply with any stricter requirements under federal or state law that may apply to our administration of your benefits. However, Delta Dental may change this notice and make the new notice effective for all of your PHI that Delta Dental maintains. If Delta Dental makes any substantive changes to their privacy practices, they will promptly change this notice and redistribute to you within 60 days of the change to their practices. You may also request a copy of this notice anytime by contacting the address or phone number for Delta Dental at the end of this notice. You should receive a copy of this notice at the time of enrollment in a Delta Dental program, and they will notify you of how you can receive a copy of this notice at least once every three years.

### **Permitted Uses and Disclosures of Your PHI**

Delta Dental is permitted to use or disclose your PHI without your prior authorization for the following purposes. These permitted uses and/or disclosures include disclosures to you, uses and/or disclosures for purposes of health care treatment, payment of claims, billing of premiums, and other health care operations. If your benefit plan is sponsored by your employer or another party, Delta Dental may provide PHI to your employer or that sponsor for purposes of

administering your benefits. Delta Dental may disclose PHI to third parties that perform services for Delta Dental in the administration of your benefits. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Delta Dental in the administration of your benefits. These affiliates have implemented privacy policies and procedures and comply with applicable federal and state law.

Delta Dental is also permitted to use and/or disclose your PHI to comply with a valid authorization, to notify or assist in notifying a family member, another person, or a personal representative of your condition, to assist in disaster relief efforts, and to report victims of abuse, neglect, or domestic violence. Other permitted uses and/or disclosures are for purposes of health oversight by government agencies, judicial, administrative, or other law enforcement purposes, information about decedents to coroners, medical examiners and funeral directors, for research purposes, for organ donation purposes, to avert a serious threat to health or safety, for specialized government functions such as military and veterans activities, for workers compensation purposes, and for use in creating summary information that can no longer be traced to you.

Additionally, with certain restrictions, Delta Dental is permitted to use and/or disclose your PHI for underwriting. Delta Dental is also permitted to incidentally use and/or disclose your PHI during the course of a permitted use and/or disclosure, but we must attempt to keep incidental uses and/or disclosures to a minimum. Delta Dental uses administrative, technical, and physical safeguards to maintain the privacy of your PHI, and they must limit the use and/or disclosure of your PHI to the minimum amount necessary to accomplish the purpose of the use and/or disclosure.

### **Examples of Uses and Disclosures of Your PHI for Treatment, Payment or Healthcare Operations**

Such activities may include but are not limited to: processing your claims, collecting enrollment information and premiums, reviewing the quality of health care you receive, providing customer service, resolving your grievances, and sharing payment information with other insurers.

Additional examples include the following.

- Uses and/or disclosures of PHI in facilitating treatment.  
*For example, Delta Dental may use or disclose your PHI to determine eligibility for services requested by your provider.*
- Uses and/or disclosures of PHI for payment.  
*For example, Delta Dental may use and disclose your PHI to bill you or your plan sponsor.*
- Uses and/or disclosures of PHI for health care operations.  
*For example, Delta Dental may use and disclose your PHI to review the quality of care provided by our network of providers.*

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## Disclosures without an Authorization

Delta Dental is required to disclose your PHI to you or your authorized personal representative (with certain exceptions), when required by the U. S. Secretary of Health and Human Services to investigate or determine their compliance with law, and when otherwise required by law. Delta Dental may disclose your PHI without your prior authorization in response to the following:

- Court order;
- Order of a board, commission, or administrative agency for purposes of adjudication pursuant to its lawful authority;
- Subpoena in a civil action;
- Investigative subpoena of a government board, commission, or agency;
- Subpoena in an arbitration;
- Law enforcement search warrant; or
- Coroner's request during investigations

## Disclosures Delta Dental Makes With Your Authorization

Delta Dental will not use or disclose your PHI without your prior authorization if the law requires your authorization. You can later revoke that authorization in writing to stop any future use and disclosure. The authorization will be obtained from you by Delta Dental or by a person requesting your PHI from Delta Dental.

## Your Rights Regarding PHI

**You have the right to request an inspection of and obtain a copy of your PHI.** You may access your PHI by contacting the appropriate Delta Dental office. You must include (1) your name, address, telephone number and identification number and (2) the PHI you are requesting. Delta Dental may charge a reasonable fee for providing you copies of your PHI. Delta Dental will only maintain that PHI that they obtain or utilize in providing your health care benefits.

Most PHI, such as treatment records or X-rays, is returned by Delta Dental to the dentist after they have completed our review of that information. You may need to contact your health care provider to obtain PHI that Delta Dental does not possess.

You may not inspect or copy PHI compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, or PHI that is otherwise not subject to disclosure under federal or state law. In some circumstances, you may have a right to have this decision reviewed. Please contact the Delta Dental privacy office as noted below if you have questions about access to your PHI.

**You have the right to request a restriction of your PHI.** You have the right to ask that Delta Dental limit how they use and disclose your PHI. Delta Dental will consider your request but are not legally required to accept it. If Delta Dental accepts your request, they will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that they are legally required or allowed to make.

**You have the right to correct or update your PHI.** This means that you may request an amendment of PHI about you for as long as Delta Dental maintains this information. In certain cases they may deny your request for an amendment. If Delta Dental denies your request for amendment, you have the right to file a statement of disagreement with Delta Dental and they may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. If your PHI was sent to Delta Dental by another, they may refer you to that person to amend your PHI. For example, Delta Dental may refer you to your dentist to amend your treatment chart or to your employer, if applicable, to amend your enrollment information. Please contact the privacy office as noted below if you have questions about amending your PHI.

**You have the right to request or receive confidential communications from us by alternative means or at a different address.** Delta Dental will agree to a reasonable request if you tell them that disclosure of your PHI could endanger you. You may be required to provide Delta Dental with a statement of possible danger, a different address, another method of contact or information as to how payment will be handled. Please make this request in writing to the privacy office as noted below.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.** This right does not apply to disclosures for purposes of treatment, payment, or health care operations or for information Delta Dental disclosed after they received a valid authorization from you. Additionally, Delta Dental does not need to account for disclosures made to you, to family members or friends involved in your care, or for notification purposes. Delta Dental does not need to account for disclosures made for national security reasons or certain law enforcement purposes, disclosures made as part of a limited data set, incidental disclosures, or disclosures made prior to April 14, 2003. Please contact the privacy office as noted below if you would like to receive an accounting of disclosures or if you have questions about this right.

**You have the right to get this notice by e-mail.** You have the right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

## **Complaints**

You may complain to us or to the U. S. Secretary of Health and Human Services if you believe that Delta Dental has violated your privacy rights. You may file a complaint with Delta Dental by notifying the privacy office as noted below. Delta Dental will not retaliate against you for filing a complaint.

## Contacts

You may contact the Privacy Department at the address and telephone number listed below for further information about the complaint process or any of the information contained in this notice.

Delta Dental of California  
Contracts and Compliance  
Attn: Privacy Contact  
P.O. Box 537010  
Sacramento, California 95853-7010  
(877) 580-1042  
TTY (877) 735-2922 or call 711

**This notice is effective on and after July 1, 2006.**

<b>Section 1.5</b>	<b>We must give you information about the plan, its network of providers, and your covered services</b>
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers and pharmacies in the plan's network, see the Provider Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at [www.partnershiphp.org](http://www.partnershiphp.org).

- **Information about your coverage and rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

<b>Section 1.6</b>	<b>We must support your right to make decisions about your care</b>
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### **You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

### **You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t.

You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### **What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the California Department of Public Health (CDPH). You may file a complaint online by visiting [www.cdph.ca.gov](http://www.cdph.ca.gov) or call at 916-558-1784 for general information.

<b>Section 1.7</b>	<b>You have the right to make complaints and to ask us to reconsider decisions we have made</b>
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the back cover of this booklet).

<b>Section 1.8</b>	<b>What can you do if you think you are being treated unfairly or your rights are not being respected?</b>
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**If it is about discrimination, call the Office for Civil Rights**

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

**Is it about something else?**

If you think you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can 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.

<b>Section 1.9</b>	<b>How to get more information about your rights</b>
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There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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## **SECTION 2      You have some responsibilities as a member of the plan**

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<b>Section 2.1      What are your responsibilities?</b>
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Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
  
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** *Please call Member Services to let us know.*
  - We are required to follow rules set by Medicare and Medi-Cal (Medicaid) to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
  
- **Tell your doctor and other health care providers that you are enrolled in our plan.** *Show your plan membership card whenever you get your medical care or Part D prescription drugs.*
  
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- **Pay what you owe.** *As a plan member, you are responsible for these payments:*
  - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For most Partnership *Advantage* members, Medi-Cal (Medicaid) pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medi-Cal is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount). Chapter 6 tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- **Tell us if you move.** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).*
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call member services for help if you have questions or concerns.** *We also welcome any suggestions you may have for improving our plan.*
  - Phone numbers and calling hours for Member Services are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

### **BACKGROUND**

<b>SECTION 1</b>	<b>Introduction.....</b>	<b>139</b>
Section 1.1	What to do if you have a problem or concern.....	139
Section 1.2	What about the legal terms?.....	139
<b>SECTION 2</b>	<b>You can get help from government organizations that are not connected with us.....</b>	<b>140</b>
Section 2.1	Where to get more information and personalized assistance.....	140
<b>SECTION 3</b>	<b>To deal with your problem, which process should you use? .....</b>	<b>142</b>
Section 3.1	Should you use the process for Medicare benefits or Medi-Cal (Medicaid) benefits? .....	142

### **PROBLEMS ABOUT YOUR MEDICARE BENEFITS**

<b>SECTION 4</b>	<b>Handling problems about your <u>Medicare</u> benefits.....</b>	<b>143</b>
Section 4.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?.....	143
<b>SECTION 5</b>	<b>A guide to the basics of coverage decisions and appeals.....</b>	<b>144</b>
Section 5.1	Asking for coverage decisions and making appeals: the big picture .....	144
Section 5.2	How to get help when you are asking for a coverage decision or making an appeal .....	145
Section 5.3	Which section of this chapter gives the details for <u>your</u> situation? .....	145
<b>SECTION 6</b>	<b>Your medical care: How to ask for a coverage decision or make an appeal .....</b>	<b>146</b>

---

Section 6.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care .....	146
Section 6.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want) .....	148
Section 6.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan) .....	151
Section 6.4	Step-by-step: How to make a Level 2 Appeal .....	153
Section 6.5	What if you are asking us to pay you back for a bill you have received for medical care? .....	155
<b>SECTION 7</b>	<b>Your Part D prescription drugs: How to ask for a coverage decision or make an appeal .....</b>	<b>156</b>
Section 7.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug .....	156
Section 7.2	What is an exception? .....	158
Section 7.3	Important things to know about asking for exceptions .....	159
Section 7.4	Step-by-step: How to ask for a coverage decision, including an exception .....	160
Section 7.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) .....	163
Section 7.6	Step-by-step: How to make a Level 2 Appeal .....	165
<b>SECTION 8</b>	<b>How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon .....</b>	<b>167</b>
Section 8.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights .....	168
Section 8.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date .....	169
Section 8.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date .....	172
Section 8.4	What if you miss the deadline for making your Level 1 Appeal? .....	173

<b>SECTION 9</b>	<b>How to ask us to keep covering certain medical services if you think your coverage is ending too soon .....</b>	<b>176</b>
Section 9.1	<i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services .....	176
Section 9.2	We will tell you in advance when your coverage will be ending .....	176
Section 9.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	177
Section 9.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	179
Section 9.5	What if you miss the deadline for making your Level 1 Appeal? .....	180
<b>SECTION 10</b>	<b>Taking your appeal to Level 3 and beyond .....</b>	<b>183</b>
Section 10.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals .....	183
Section 10.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	185
<b>SECTION 11</b>	<b>How to make a complaint about quality of care, waiting times, customer service, or other concerns .....</b>	<b>186</b>
Section 11.1	What kinds of problems are handled by the complaint process?.....	186
Section 11.2	The formal name for “making a complaint” is “filing a grievance” .....	188
Section 11.3	Step-by-step: Making a complaint .....	189
Section 11.4	You can also make complaints about quality of care to the Quality Improvement Organization .....	190

## **PROBLEMS ABOUT YOUR MEDI-CAL (MEDICAID) BENEFITS**

<b>SECTION 12</b>	<b>Handling problems about your <u>Medi-Cal</u> benefits.....</b>	<b>191</b>
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## BACKGROUND

### SECTION 1 Introduction

#### Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medi-Cal (Medicaid)**. If you would like help deciding whether to use the Medicare process or the Medi-Cal process, or both, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)
2. The type of problem you are having:
  - For some types of problems, you need to use the **process for coverage decisions and making appeals**.
  - For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

#### Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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## **SECTION 2      You can get help from government organizations that are not connected with us**

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<b>Section 2.1      Where to get more information and personalized assistance</b>
---

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

### **Get help from an independent government organization**

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

### **You can also get help and information from Medicare**

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 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 visit the Medicare website (<http://www.medicare.gov>).

### **You can get help and information from Medi-Cal (Medicaid)**

To get help from Medi-Cal, you can contact either the Medi-Cal Managed Care Ombudsman at the Department of Health Care Services or contact your local Medi-Cal office. These phone numbers are also listed in Chapter 2, Section 6 of this EOC.

<b>California Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman</b>	
<b>CALL</b>	888-452-8609
<b>WRITE</b>	P.O. Box 997413, MS 4400 Sacramento, CA 95899-7413
<b>WEBSITE</b>	<a href="http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx">http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx</a>

<b>Local Medi-Cal Offices</b>	
<b>CALL</b>	<p><u>For Napa County:</u> 707-253-4511</p> <p><u>For Solano County:</u> Fairfield – 707-784-8050 Vacaville – 707-469-4500 Vallejo – 707-553-5000</p> <p><u>For Yolo County:</u> Woodland – 530-661-2750 West Sacramento – 916-375-6200</p>
<b>WRITE</b>	<p><u>For Napa County:</u> Department of Health and Human Services 2261 Elm Street Napa, CA 94559</p> <p><u>For Solano County:</u> Call the numbers above for the nearest office</p> <p><u>For Yolo County:</u> Department of Employment and Social Services 25 N. Cottonwood Street Woodland, CA 95695</p> <p>Or, the West Sacramento office at:</p> <p>500-A Jefferson Blvd West Sacramento, CA 95605</p>
<b>WEBSITE</b>	<p>For Napa County: <a href="http://countyofnapa.org/Pages/DepartmentContent.aspx?id=4294967830">http://countyofnapa.org/Pages/DepartmentContent.aspx?id=4294967830</a></p>

For Solano County:  
[http://www.solanocounty.com/depts/hss/ees/medical/medi\\_cal.asp](http://www.solanocounty.com/depts/hss/ees/medical/medi_cal.asp)

For Yolo County:  
<http://www.yolocounty.org/index.aspx?page=559>

**SECTION 3      To deal with your problem, which process should you use?**

**Section 3.1      Should you use the process for Medicare benefits or Medi-Cal (Medicaid) benefits?**

Because you have Medicare and get assistance from Medi-Cal, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medi-Cal benefits. If your problem is about a benefit covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medi-Cal, then you should use the Medi-Cal process. If you would like help deciding whether to use the Medicare process or the Medi-Cal process, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)

The Medicare process and Medi-Cal process are described in different parts of this chapter. To find out which part you should read, use the chart below.

<p>To figure out which part of this chapter will help with your specific problem or concern,  <b>START HERE</b></p>	
<p><b>Is your problem about Medicare benefits or Medi-Cal benefits?</b></p> <p>(If you would like help deciding whether your problem is about Medicare benefits or Medi-Cal benefits, please contact Member Services.)</p>	
<p style="text-align: center;">My problem is about  <b>Medicare</b> benefits.</p> <p>Go to the next section of this chapter,  <b>Section 4, “Handling problems about Medicare your benefits.”</b></p>	<p style="text-align: center;">My problem is about  <b>Medi-Cal</b> benefits.</p> <p>Skip ahead to <b>Section 12</b> of this chapter,  <b>“Handling problems about your Medi-Cal benefits.”</b></p>

## PROBLEMS ABOUT YOUR MEDICARE BENEFITS

### SECTION 4 Handling problems about your Medicare benefits

**Section 4.1**      **Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?**

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

#### **Is your problem or concern about your benefits or coverage?**

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

#### **Yes.**

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and making appeals.”**

#### **No.**

My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

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## **SECTION 5      A guide to the basics of coverage decisions and appeals**

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<b>Section 5.1      Asking for coverage decisions and making appeals: the big picture</b>
---

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

### **Asking for coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

### **Making an appeal**

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 make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

<b>Section 5.2</b>	<b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at [www.partnershiphp.org](http://www.partnershiphp.org)). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

<b>Section 5.3</b>	<b>Which section of this chapter gives the details for <u>your</u> situation?</b>
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”

- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call Member Services (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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## **SECTION 6      Your medical care: How to ask for a coverage decision or make an appeal**

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Have you read Section 5 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)?

If not, you may want to read it before you start this section.

<b>Section 6.1</b>	<b>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Benefits Chart (what is covered)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
  - Chapter 9, Section 8: *How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
  - Chapter 9, Section 9: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

<b>Which of these situations are you in?</b>	
<b>If you are in this situation:</b>	<b>This is what you can do:</b>
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you.  Go to the next section of this chapter, <b>Section 6.2.</b>
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an <b>appeal</b> . (This means you are asking us to reconsider.)  Skip ahead to <b>Section 6.3</b> of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill.  Skip ahead to <b>Section 6.5</b> of this chapter.

<b>Section 6.2</b>	<b>Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)</b>
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<b>Legal Terms</b>	When a coverage decision involves your medical care, it is called an “ <b>organization determination.</b> ”
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**Step 1: You ask our plan to make a coverage decision on the medical care you are requesting.** If your health requires a quick response, you should ask us to make a “**fast decision.**”

<b>Legal Terms</b>	A “fast decision” is called an “ <b>expedited determination.</b> ”
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*How to request coverage for the medical care you want*

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

*Generally we use the standard deadlines for giving you our decision*

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will 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 the process for making complaints, including fast complaints, see Section 11 of this chapter.)

*If your health requires it, ask us to give you a “fast decision”*

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get

information to us for the review. If we decide to take extra days, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

## **Step 2: We consider your request for medical care coverage and give you our answer.**

### *Deadlines for a “fast” coverage decision*

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

- If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### *Deadlines for a “standard” coverage decision*

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### **Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
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**Step 1: You contact us and make your appeal.** If your health requires a quick response, you must ask for a “fast appeal.”

*What to do*

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at [www.partnershiphp.org](http://www.partnershiphp.org)). While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**

- You have the right to ask us for a copy of the information regarding your appeal.
- If you wish, you and your doctor may give us additional information to support your appeal.

*If your health requires it, ask for a “fast appeal” (you can make a request by calling us)*

**Legal Terms** A “fast appeal” is also called an “**expedited reconsideration.**”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

### **Step 2: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

#### *Deadlines for a “fast” appeal*

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

#### *Deadlines for a “standard” appeal*

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
  - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

#### **Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

<b>Section 6.4</b> <b>Step-by-step: How to make a Level 2 Appeal</b>
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If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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### **Step 1: The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a 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 will take a careful look at all of the information related to your appeal.

*If you had a “fast” appeal at Level 1, you will also have a “**fast**” appeal at Level 2*

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

*If you had a “standard” appeal at Level 1, you will also have a “**standard**” appeal at Level 2*

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

### **Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care

should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

- The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

**Step 3: 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 of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 6.5</b>	<b>What if you are asking us to pay you back for a bill you have received for medical care?</b>
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If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

**Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Benefits Chart (what is covered)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan’s coverage for your medical services*).

**We will say yes or no to your request**

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we receive your

request. Or, if you haven't paid for the services, 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 medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

### What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

**To make this appeal, follow the process for appeals that we describe in part 5.3 of this section.** Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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## SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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Have you read Section 5 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)?

If not, you may want to read it before you start this section.

<b>Section 7.1</b>	<b>This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug</b>
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our plan's *List of Covered Drugs (Formulary)* and the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

## Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

<b>Legal Terms</b>	An initial coverage decision about your Part D drugs is called a “ <b>coverage determination.</b> ”
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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 the plan’s *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Formulary or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with <b>Section 7.2</b> of this chapter.</p>	<p>Do you want us to cover a drug on our Formulary and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to <b>Section 7.5</b> of this chapter.</p>

## Section 7.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, 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 will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Formulary” for short.)

<b>Legal Terms</b>	Asking for coverage of a drug that is not on the Formulary is sometimes called asking for a “ <b>formulary exception.</b> ”
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- If we agree to make an exception and cover a drug that is not on the Formulary, you will need to pay the cost-sharing amount that applies to drugs in brand drug tier (tier 2) for brand name drugs. You cannot ask for an exception to the copayment amount we require you to pay for the drug.
- You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

**2. Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 5).

<b>Legal Terms</b>	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a <b>“formulary exception.”</b>
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- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

**3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Formulary is in one of two (2) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

<b>Legal Terms</b>	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a <b>“tiering exception.”</b>
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- If your drug is in brand drug tier (tier 2) you can ask us to cover it at the cost-sharing amount that applies to drugs in the generic drug tier (tier 1). This would lower your share of the cost for the drug.

<b>Section 7.3</b>	<b>Important things to know about asking for exceptions</b>
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**Your doctor must tell us the medical reasons**

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

Typically, our Formulary includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

### **We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

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

<b>Section 7.4</b>	<b>Step-by-step: How to ask for a coverage decision, including an exception</b>
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**Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a “fast decision.” **You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

#### *What to do*

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

*If your health requires it, ask us to give you a “fast decision”*

<b>Legal Terms</b>	A “fast decision” is called an <b>“expedited coverage determination.”</b>
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our 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 the process for making complaints, see Section 11 of this chapter.)

## **Step 2: We consider your request and we give you our answer.**

*Deadlines for a “fast” coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

*Deadlines for a "standard" coverage decision about a drug you have not yet received*

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

*Deadlines for a "standard" coverage decision about payment for a drug you have already bought*

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization.

Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

<b>Section 7.5</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a Part D drug coverage decision is called a plan “ <b>redetermination.</b> ”
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**Step 1: You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a “**fast appeal.**”

*What to do*

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (How to contact our plan when you are making an appeal about your part D prescription drugs).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the

deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

<b>Legal Terms</b>	A “fast appeal” is also called an “ <b>expedited redetermination.</b> ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 7.4 of this chapter.

## **Step 2: Our plan considers your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

### *Deadlines for a “fast” appeal*

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

### Deadlines for a “**standard**” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

### **Step 3:** If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for “fast” appeal at Level 2*

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for “standard” appeal at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**

- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

### **What if the review organization says no to your appeal?**

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

### **Step 3: If the dollar value of the coverage you are requesting meets the requirement, 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 of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## **SECTION 8      How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**

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When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

<b>Section 8.1</b>	<b>During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b>
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During your hospital stay, you will be given 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. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services. 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.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

<b>Legal Terms</b>	The written notice from Medicare tells you how you can “ <b>request an immediate review.</b> ” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)
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- 2. You must sign the written notice to show that you received it and understand your rights.**
  - You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
  - To look at a copy of this notice in advance, you can call Member Services 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 see it online at [http://www.cms.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp).

**Section 8.2      Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date**

If you want to ask for your hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

**Legal Terms**      A “fast review” is also called an “**immediate review.**”

*What is the Quality Improvement Organization?*

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for

people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

### *How can you contact this organization?*

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

### *Act quickly:*

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

### *Ask for a “fast review”:*

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

<b>Legal Terms</b>	A “fast review” is also called an “ <b>immediate review</b> ” or an “ <b>expedited review</b> .”
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## **Step 2: The Quality Improvement Organization conducts an independent review of your case.**

### *What happens during this review?*

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

<b>Legal Terms</b>	This written explanation is called the “ <b>Detailed Notice of Discharge</b> .” You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at <a href="http://www.cms.hhs.gov/BNL/">http://www.cms.hhs.gov/BNL/</a>
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**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

*What happens if the answer is yes?*

- If the review organization says *yes* to your appeal, **we must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

*What happens if the answer is no?*

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 8.3</b>	<b>Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date</b>
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

*If the review organization says yes:*

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

*If the review organization says no:*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 8.4</b>	<b>What if you miss the deadline for making your Level 1 Appeal?</b>
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**You can appeal to us instead**

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

**Step-by-Step: How to make a Level 1 *Alternate* Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

<b>Legal Terms</b>	A “fast” review (or “fast appeal”) is also called an “ <b>expedited appeal</b> ”.
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**Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

**Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.

- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

**Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

**Step-by-Step: How to make a Level 2 *Alternate* Appeal**

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the <b>“Independent Review Entity.”</b> It is sometimes called the <b>“IRE.”</b>
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**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines,

you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

**Step 3: If the Independent Review Organization turns down your appeal, 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 of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## SECTION 9      How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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<b>Section 9.1</b>	<b><i>This section is about three services <u>only</u>: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</i></b>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Benefits Chart (what is covered)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying for your care*.

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

<b>Section 9.2</b>	<b>We will tell you in advance when your coverage will be ending</b>
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

<b>Legal Terms</b>	In telling you what you can do, the written notice is telling how you can request a “ <b>fast-track appeal.</b> ” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)
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<b>Legal Terms</b>	The written notice is called the “ <b>Notice of Medicare Non-Coverage.</b> ” To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <a href="http://www.cms.hhs.gov/BNI/">http://www.cms.hhs.gov/BNI/</a>
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## 2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

<b>Section 9.3</b>	<b>Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time</b>
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**

**Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.**

*What is the Quality Improvement Organization?*

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

*How can you contact this organization?*

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

*What should you ask for?*

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

*Your deadline for contacting this organization.*

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

*What happens during this review?*

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

<b>Legal Terms</b>	This notice explanation is called the “ <b>Detailed Explanation of Non-Coverage.</b> ”
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**Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

*What happens if the reviewers say yes to your appeal?*

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

*What happens if the reviewers say no to your appeal?*

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 9.4</b>	<b>Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time</b>
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

*What happens if the review organization says yes to your appeal?*

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

*What happens if the review organization says no?*

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 9.5</b>	<b>What if you miss the deadline for making your Level 1 Appeal?</b>
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**You can appeal to us instead**

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline

for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

### **Step-by-Step: How to make a Level 1 *Alternate Appeal***

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

**Legal Terms** A “fast” review (or “fast appeal”) is also called an “**expedited appeal**”.

#### **Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

#### **Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

#### **Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal**, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

**Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

**Step-by-Step: How to make a Level 2 *Alternate* Appeal**

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal**, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

**Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## **SECTION 10 Taking your appeal to Level 3 and beyond**

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<b>Section 10.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals</b>
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<p><b>Level 3 Appeal</b> A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”</p>
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- **If the Administrative Law Judge says *yes* to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a

decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
- If we decide to appeal the decision, we will 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 the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

**Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals**

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal** A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a

Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

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## **SECTION 11      How to make a complaint about quality of care, waiting times, customer service, or other concerns**

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If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

**Section 11.1      What kinds of problems are handled by the complaint process?**

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems,  
you can “make a complaint”**

**Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

**Respecting your privacy**

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

**Disrespect, poor customer service, or other negative behaviors**

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

**Waiting times**

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

**Cleanliness**

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

**Information you get from us**

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

*The next page has more examples of  
possible reasons for making a complaint*

### Possible complaints (continued)

#### These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

#### Section 11.2      The formal name for “making a complaint” is “filing a grievance”

##### Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

**Section 11.3 Step-by-step: Making a complaint****Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call Member Services at 866-264-3626 from 8am to 8pm, 7 days a week. TTY users can call 800-735-2929 (CRS) or dial 711.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, put your complaint in writing, we will respond to your complaint in writing.
  - After receiving your written complaint, plan staff will respond in writing to confirm the acknowledgement of your complaint within 5 calendar days and will also contact you by phone to further discuss your grievance.
  - A written resolution letter will be sent to you within 30 calendar days once the plan makes a decision regarding your grievance. Any quality of care issues will also include in your grievance resolution letter the contact information for the QIO.

**For Expedited Requests:**

- After receiving your written complaint, plan staff will contact you within 2 hours by phone to further discuss your grievance.
  - Plan staff will contact you within 24 hours once the plan makes a decision regarding your grievance. Any quality of care issues will also include in your grievance resolution letter the contact information for the QIO.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

<b>Legal Terms</b>	What this section calls a “fast complaint” is also called an “expedited grievance.”
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**Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

<b>Section 11.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
  - 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 find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

## **PROBLEMS ABOUT YOUR MEDI-CAL (MEDICAID) BENEFITS**

### **SECTION 12 Handling problems about your Medi-Cal benefits**

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Once you have exhausted your grievance and appeal rights under Medicare, you can use your Medi-Cal grievance and appeal rights. If the service about which you are filing a grievance or appeal is a Medi-Cal only covered service, you will use your Medi-Cal rights only.

The following information can be found in your Medi-Cal Handbook. You can also call Member Services at the phone number listed in Chapter 2, Section 1 of this EOC.

#### **Your Medi-Cal Grievance and Appeal Rights**

PHC has a complaint and appeal system to help you resolve problems with medical care and/or service. If you need help solving a problem, please call our Member Services Department at **707-863-4120** or **800-863-4155** to file a complaint or an appeal.

You have the right to file a complaint or an appeal if you disagree with a decision by PHC, one of its providers or if you are not happy with the service you received. You must file your complaint within one hundred eighty (180) calendar days following any incident or action in which you were dissatisfied. If you decide to file a complaint or an appeal, you may do so by telephone, in writing or in person.

Written complaints or appeals should be forwarded to:

**Partnership HealthPlan of California  
Grievance Unit Department  
360 Campus Lane, Suite 100  
Fairfield, CA 94534**

To file a complaint or appeals in person contact the Member Services Department by calling **800-863-4155**.

You can also file a complaint or appeal at your provider's office.

A decision issued by PHC is made in a "Notice of Action", which is a formal letter telling you that a medical service has been denied, deferred, or modified. If you receive a Notice of Action from PHC, you have two options for filing a grievance:

- ◆ You must file your appeal within ninety (90) calendar days from the date on the Notice of Action.

- ◆ You may also request a State Hearing from the Department of Social Services (DSS) within ninety (90) calendar days. For more information about State Hearings refer to the section below titled State Hearings.
- ◆ You may be able to keep getting the services while you appeal the decision through a State Hearing. This is called “Aid Paid Pending. See details under Aid Paid Pending below.

PHC will send you an acknowledgement letter within five (5) calendar days of the date your complaint or appeal was received by PHC. PHC will send you a written resolution to your complaint or appeal within thirty (30) calendar days of the date your complaint or appeal was filed. PHC will make every effort to resolve your complaint or appeal within thirty (30) calendar days. However, if there is some reason this is not possible, you will be notified by letter that additional time is required. PHC will then send you a written resolution within an additional fifteen (15) calendar days.

If you are not satisfied with our resolution, you may request a State Hearing. To file a State Hearing, refer to Section 5 of this handbook for more information.

If you feel that a delay in processing your complaint or appeal through the normal grievance process would create a serious threat to your health, including, but not limited to severe pain, potential loss of life, limb or major bodily function you can request an expedited review. Our medical staff will determine if your request for an expedited review meets the criteria listed above. When an expedited review is necessary, PHC will issue a written statement on the status of your complaint or appeal within three (3) calendar days of the time it was received.

Please note, you **do not** have to file a complaint or appeal through PHC. You have the right to file a State Hearing if you disagree with a decision made by PHC or one of its providers or if you want to file a complaint. You may file a State Hearing before, during or after filing with PHC. See the State Hearing section below for more information.

PHC does not handle issues about your Medi-Cal eligibility. For eligibility issues contact your County Eligibility Worker.

## **State Hearings**

All Medi-Cal beneficiaries have the right to request a State Hearing to appeal a decision by PHC or to file a complaint about the service they received from PHC or one of our providers. You must request the State Hearing within ninety (90) days from the date of the action that you are dissatisfied with. If you request a State Hearing from the California Department of Social Services, your case will be reviewed by an administrative law judge. The judge will send you a decision on your case within ninety (90) calendar days of the date of your hearing.

## Expedited State Hearings

If you feel that a delay in processing your State Hearing through the standard timeframe would create a serious threat to your health, including, but not limited to severe pain, potential loss of life, limb or major bodily function you can request an expedited State Hearing by contacting the State Hearing division at the numbers listed below.

### State Hearing Contact Information

There are three ways to request a State Hearing:

1. By calling: **1-800-952-5253** or **TDD 1-800-952-8349**
2. By writing to: **California Department of Social Services  
State Hearing Division  
PO BOX 944243  
Mail Station 19-37  
Sacramento, CA 94244-2430**
3. By fax: **1-916-651-2727**

You may write your own request for a State Hearing or you may use the form on the back of the Notice of Action you received.

## Aid Paid Pending

If you have received a notice that PHC has decided to reduce, suspend or terminate medical services, you may be able to keep getting the services while you appeal the decision through a State Hearing. This is called “Aid Paid Pending.” You are eligible for Aid Paid Pending if:

- ◆ You request a State Hearing on or before the tenth (10<sup>th</sup>) day after a written decision is sent to you so that services you have been receiving on an ongoing basis will not be reduced, suspended, or terminated **OR** before the date of the proposed action, whichever is later, and the treating PHC physician has ordered the services at the present level.

PHC will continue to provide services at a level equal to the level ordered by the physician until a final decision is made by the administrative law judge.

## State Medi-Cal Managed Care Ombudsman

The State of California has an Ombudsman to help you when you are unable to solve problems you have with your health plan. The primary mission of the Ombudsman’s Office is to investigate and attempt to find resolution to complaints about managed care made by or on behalf of Medi-Cal beneficiaries. The Ombudsman also works to ensure that access and high quality of managed care services are being provided to the Medi-Cal beneficiaries.

You should first try to work with PHC to resolve any issues you have with PHC benefits or services received from our providers. If you are unable to resolve the issue, you may call the State Ombudsman Unit at 1-888-452-8609 between 8:00 a.m. – 12:00 noon and 1:00 p.m. – 5:00 p.m. Monday through Friday.

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## **Chapter 10. Ending your membership in the plan**

<b>SECTION 1</b>	<b>Introduction</b> .....	<b>196</b>
Section 1.1	This chapter focuses on ending your membership in our plan .....	196
<b>SECTION 2</b>	<b>When can you end your membership in our plan?</b> .....	<b>196</b>
Section 2.1	You can end your membership at any time .....	196
Section 2.2	Where can you get more information about when you can end your membership? .....	197
<b>SECTION 3</b>	<b>How do you end your membership in our plan?</b> .....	<b>197</b>
Section 3.1	Usually, you end your membership by enrolling in another plan.....	197
<b>SECTION 4</b>	<b>Until your membership ends, you must keep getting your medical services and drugs through our plan</b> .....	<b>199</b>
Section 4.1	Until your membership ends, you are still a member of our plan.....	199
<b>SECTION 5</b>	<b>Partnership <i>Advantage</i> must end your membership in the plan in certain situations</b> .....	<b>199</b>
Section 5.1	When must we end your membership in the plan? .....	199
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	200
Section 5.3	You have the right to make a complaint if we end your membership in our plan .....	200

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>This chapter focuses on ending your membership in our plan</b>
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Ending your membership in Partnership *Advantage* may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends. You will continue to receive your Medi-Cal (Medicaid) benefits through PHC so long as you continue to live in PHC's Medi-Cal service area. If you are moving you can contact Member Services to learn if you will remain with PHC Medi-Cal.

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## SECTION 2 When can you end your membership in our plan?

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<b>Section 2.1</b>	<b>You can end your membership at any time</b>
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You can end your membership in Partnership *Advantage* at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medi-Cal, **you can end your membership in Partnership *Advantage* at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)

- Original Medicare *with* a separate Medicare prescription drug plan.
  - 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 have opted out of automatic enrollment.
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</b>	<b>Where can you get more information about when you can end your membership?</b>
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **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.

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## **SECTION 3**      **How do you end your membership in our plan?**

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<b>Section 3.1</b>	<b>Usually, you end your membership by enrolling in another plan</b>
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- *--or--* You can contact 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.

The table below explains how you should end your membership in our plan.

<b>If you would like to switch from our plan to:</b>	<b>This is what you should do:</b>
<ul style="list-style-type: none"><li>• Another Medicare health plan.</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare health plan.  You will automatically be disenrolled from Partnership <i>Advantage</i> when your new plan's coverage begins.  You will continue to receive your Medi-Cal benefits through PHC.</li></ul>
<ul style="list-style-type: none"><li>• Original Medicare <i>with</i> a separate Medicare prescription drug plan.</li></ul>	<ul style="list-style-type: none"><li>• Enroll in the new Medicare prescription drug plan.  You will automatically be disenrolled from Partnership <i>Advantage</i> when your new plan's coverage begins.</li></ul>
<ul style="list-style-type: none"><li>• Original Medicare <i>without</i> a separate Medicare prescription drug plan.<ul style="list-style-type: none"><li>○ 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 have opted out of automatic enrollment.</li></ul></li></ul>	<ul style="list-style-type: none"><li>• <b>Send us a written request to disenroll.</b> Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).</li><li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li><li>• You will be disenrolled from Partnership <i>Advantage</i> when your coverage in Original Medicare begins.</li></ul>

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## **SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our plan**

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<b>Section 4.1      Until your membership ends, you are still a member of our plan</b>
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If you leave Partnership *Advantage*, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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## **SECTION 5      Partnership *Advantage* must end your membership in the plan in certain situations**

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<b>Section 5.1      When must we end your membership in the plan?</b>
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**Partnership *Advantage* must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for Medi-Cal (Medicaid). As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medi-Cal. You must regain full-scope Medi-Cal benefits within 60 days if the first day of the month after you lose your full-scope Medi-Cal coverage.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- 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.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

### Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the back cover of this booklet).

<b>Section 5.2</b>	<b>We <u>cannot</u> ask you to leave our plan for any reason related to your health</b>
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### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

<b>Section 5.3</b>	<b>You have the right to make a complaint if we end your membership in our plan</b>
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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 make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

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**Chapter 11. Legal notices**

**SECTION 1 Notice about governing law ..... 202**

**SECTION 2 Notice about nondiscrimination ..... 202**

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## **SECTION 1      Notice about governing law**

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Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

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## **SECTION 2      Notice about nondiscrimination**

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We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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## **Chapter 12. Definitions of important words**

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

**Balance Billing** – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of Partnership *Advantage*, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 7, Section 1 for more information about balance billing.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay no copayment for your drugs after you have reached \$6,800.00 in total drug costs in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are received. Cost sharing only refers to this types of payments: any fixed “copayment” amount that a plan requires when a specific service or drug is received.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of two (2) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The general term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Deductible** – The amount you must pay for health care or prescriptions before our plan begins to pay.

**Disenroll or Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

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**Dual Eligible Individual** – A person who qualifies for Medicare and Medi-Cal (Medicaid) coverage.

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

**Grievance** - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Home Health Aide** – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your total drug expenses have reached \$2,100.00.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Institutional Special Needs Plan (SNP)** – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

**Institutional Equivalent Special Needs Plan (SNP)** – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

**List of Covered Drugs (Formulary or)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered services. (Note: Because our members also get assistance from Medi-Cal (Medicaid), very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

**Medi-Cal (Medicaid or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

**Organization Determination** – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers’ payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**Part C** – see “**Medicare Advantage (MA) Plan.**”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she 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 see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

**Quality Improvement Organization (QIO)** – 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**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 also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

**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 injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid (Medi-Cal), who reside in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Care** – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

## PartnershipAdvantage (HMO SNP) Member Services

<b>CALL</b>	866-264-3626  Calls to this number are free. 8am to 8pm, 7 days a week.  Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	800-735-2929 (through the California Relay Service, or CRS)  or dial 711  Calls to this number are free. 8am to 8pm, 7 days a week.
<b>FAX</b>	800-863-4415
<b>WRITE</b>	360 Campus Lane Suite 100 Fairfield, CA 94534  Attn: Member Services
<b>WEBSITE</b>	<a href="http://www.partnershiphp.org">www.partnershiphp.org</a>

## Health Insurance and Counseling Advocacy Program (HICAP) (California SHIP)

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

<b>Health Insurance and Counseling Advocacy Program (HICAP) (California SHIP)</b>	
<b>CALL</b>	800-434-0222
<b>WRITE</b>	5380 Elvas Avenue Suite 221 Sacramento, CA 95819
<b>WEBSITE</b>	<a href="http://www.cahealthadvocates.org">www.cahealthadvocates.org</a>