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

Introduction

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

[*Plans should refer to other parts of the Member Handbook using the appropriate chapter number, section, and/or page number as appropriate. For example, "refer to Chapter 9, Section A, page 1." An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Member Handbook. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template.*]

Table of Contents

A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook.*

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

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. [*Plans may delete the next sentence if it is not applicable.*] Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Medi-Cal. This includes certain behavioral health and LTSS.

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

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury. [*Plans may omit or edit the PCP-related bullets as necessary, including modifying the name of the PCP.*] For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - In most cases, [*insert as applicable:* your network PCP or our plan] must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. To learn more about referrals, refer to page <page number>.

- [*Insert if applicable:* Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is [*insert definition*].]
- You do not need a referral from your PCP for emergency care or urgently needed care, to use a woman's health provider, or for any of the other services listed in section D1 of this chapter.

- **You must get your care from network providers** [*insert if applicable:* **that are affiliated with your PCP's medical group**]**.** Usually, we won't cover care from a provider who doesn't work with our health plan [*insert if applicable:* and your PCP's medical group]. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to Section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. [*Plans may specify whether authorization should be obtained before seeking care.*] In this situation, we cover the care [*insert as applicable:* as if you got it from a network provider ***or*** at no cost to you].
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility. [*Insert as applicable:* The cost-sharing you pay for dialysis can never exceed the cost-sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost-sharing cannot exceed the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from an out-of-network provider the cost-sharing for the dialysis may be higher.]
  - When you first join our plan, you can ask to continue using your current providers. With some exceptions, we must approve this request if we can establish that you had an existing relationship with the providers. Refer to **Chapter 1** of your *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network [*insert if applicable:* that are affiliated with your PCP's medical group]. After 12 months, we no longer cover your care if you

continue to use providers that are not in our network [*insert if applicable:* and not affiliated with your PCP's medical group].

- [*Plans add additional exceptions as appropriate including exceptions as required by the state.*]

New members to *<plan name>*: In most instances you will be enrolled in [D-SNP name] for your Medicare benefits the 1st day of the month after you request to be enrolled in *<plan name>*. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through *<plan name>*. There will be no gap in your Medi-Cal coverage. Please call us at <phone and TTY/TDD numbers> if you have any questions.

C. Your care coordinator

[*Plans provide applicable information about the care coordinator and care coordination, as well as explanations for the following subsections. Plans should replace the terms "care coordinator" and "care team" with terms they use. If Plans use more than one type of "care coordinator," multiple descriptions can be provided that describe each type, or additional language can be added to the care coordinator definition below.*]

C1. What a care coordinator is

[*Example text:* A care coordinator is a trained person who works for our plan to provide care coordination services for you.]

C2. How you can contact your care coordinator

C3. How you can change your care coordinator

D. Care from providers

D1. Care from a primary care provider (PCP)

[*Insert if applicable and adjust language to describe PCP requirements:* You must choose a PCP to provide and manage your care. Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group.]

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

[*Plans describe the following in the context of their plans:*

What a PCP is

If applicable, what a medical group or IPA is

What types of providers may act as a PCP [*If a State allows specialists to act as a PCP, plans must inform members of this and under what circumstances a specialist may be a PCP. Obstetrician-gynecologists are eligible as primary care physicians.*]

The role of a PCP in

- coordinating covered services
- making decisions about or getting prior authorization (PA), if applicable

When a clinic can be your PCP (RHC/FQHC)]

Your choice of PCP

[*Plans describe how to choose a PCP. Plans that assign members to medical groups or IPAs must include language that explains how the choice of PCP will affect member access to specialists and hospitals. For example:* If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's medical group. You can look in the *Provider and Pharmacy Directory*, or ask Member Services to find out if the PCP you want makes referrals to that specialist or uses that hospital.]

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

[*Plans describe how to change a PCP and indicate when that change will take effect (e.g., on the first day of the month following the date of the request, immediately upon receipt of the request, etc.).*]

[*Insert if applicable:* Our plan's PCPs are affiliated with medical groups. If you change your PCP, you may also be changing medical groups. When you ask for a change, tell Member Services if you use a specialist or get other covered services that must have PCP approval. Member Services helps you continue your specialty care and other services when you change your PCP.]

Services you can get without approval from your PCP

[***Note:** Insert this section only if plans require referrals to network providers.*]

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

- emergency services from network providers or out-of-network providers

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

  Note: Urgently needed care must be immediately needed and medically necessary.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations [*insert if applicable:* as well as hepatitis B vaccinations and pneumonia vaccinations] [*insert if applicable:* as long as you get them from a network provider].
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams [*insert if applicable:* as long as you get them from a network provider].
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

[*Plans add additional bullets consistently formatted like the rest of this section as appropriate.*]

D2. Care from specialists and other network providers

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

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

[*Plans describe how members access specialists and other network providers, including:*

The role (if any) of the PCP in referring members to specialists and other providers.

A description of PA as well as the process for getting PA [*Plans explain that PA means the member gets plan approval before getting a specific service or drug or using an out-of-network provider, and plans include information about who makes the PA decision (e.g., Medical Director, the PCP, or another entity).*] Refer members to Chapter 4 for information about which services require PA.

If PCP selection results in being limited to specific specialists or hospitals to which that PCP refers [*For example, plans include information about subnetworks.*]]

[*Plans with referral models, insert:* A written referral may be for one visit or it may be a standing referral for more than one visit if you need ongoing services. We must give you a standing referral to a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a written referral when needed, the bill may not be paid. For more information, call Member Services at the number at the bottom of this page.]

[*Plans with direct access models, insert:* If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist.

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.]

D3. When a provider leaves our plan

[*Plans may edit this section if Medi-Cal requires them to have a transition benefit when a provider leaves the plan.*]

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.

- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will help you select a new qualified in-network provider to continue managing your health care needs.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. [*Plans should indicate if prior authorization is needed.*]
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** [*plans may insert reference, as applicable*] for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. [*Plans include contact information for assistance.*]

D4. Out-of-network providers

[*Plans tell members under what circumstances they can get services from out-of-network providers (e.g., when providers of specialized services are not available in network). Include Medi-Cal out-of-network requirements. Describe the process for getting authorization, including who is responsible for getting it.*] [*Note: Members are entitled to receive services from out-of-network providers for emergency or urgently needed services. In addition, plans must cover dialysis services for ESRD members who have traveled outside the plans service area or when the provider is temporarily unavailable or not accessible and are not able to access contracted ESRD providers.*]

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medi-Cal.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Medi-Cal.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

LTSS can help you stay at home and avoid a hospital or skilled nursing facility stay. You have access to certain LTSS through our plan, including skilled nursing facility care, Community Based Adult Services (CBAS), and Community Supports. Another type of LTSS, the In Home Supportive Services program is available through your county social service agency. [*Plans should provide applicable information about getting LTSS.*]

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

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare and Medi-Cal managed care. Our plan does not provide Medi-Cal specialty mental health or county substance use disorder services, but these services are available to you through [*insert the names of the county behavioral health entity(ies) responsible for delivering certain types of mental health and/or substance use disorder services*].

F1. Medi-Cal behavioral health services provided outside our plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by [*insert the names of the county entity(ies) responsible for delivering mental health and substance use disorder services*] include:

- mental health services
- medication support services
- day treatment intensive
- day rehabilitation
- crisis intervention
- crisis stabilization

- adult residential treatment services
- crisis residential treatment services
- psychiatric health facility services
- psychiatric inpatient hospital services
- targeted case management

Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through [*insert the name of the county entity responsible for delivering substance use disorder services*] if you meet criteria to receive these services. Drug Medi-Cal services provided by [*insert the name of the county entity responsible for delivering SUD services*] include:

- intensive outpatient treatment services
- residential treatment services
- outpatient drug free services
- narcotic treatment services
- naltrexone services for opioid dependence

Drug Medi-Cal Organized Delivery System Services include:

- outpatient and intensive outpatient services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential/inpatient
- withdrawal management
- narcotic treatment services
- recovery services
- care coordination

In addition to the services listed above, you may have access to voluntary inpatient detoxification services if you meet the criteria.

[*Plans must insert language about the availability of behavioral health services, processes to determine medical necessity, referral procedures between the plan and county entity, problem resolution processes, etc.*]

G. Transportation services

G1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. [*Plans may change the remainder of the paragraph as needed to reflect their operational process*.] If you need non-emergency medical transportation, you can talk to your [*insert:* PCP *or* other provider] and ask for it. Your [*insert:* PCP *or* other provider] will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they will prescribe it by completing a form and submitting it to <plan name> for approval. Depending on your medical need, the approval is good for one year. Your [*insert:* PCP *or* other provider] will reassess your need for non-emergency medical transportation for re-approval every 12 months.

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

Non-emergency medical transportation must be used when:

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

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

[*Plans may adjust contact information as appropriate when member calls vendor instead of plan*.] To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call <plan name> at [*insert plan's phone number and/or transportation provider's phone number*] at least [*insert plan's required advance notice in number of hours or business or calendar days*] (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

Medical transportation limits

<Plan name> covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation will

not be provided if Medicare or Medi-Cal does not cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, <plan name> will help you schedule your transportation. A list of covered services is in Chapter 4 of this handbook. Transportation is not covered outside <plan name's> network or service area unless pre-authorized.

G2. Non-medical transportation

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

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

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

Sometimes, you can be reimbursed for rides in a private vehicle that you arrange. <Plan name> must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. [*Plans may adjust contact information as appropriate.*] You can tell us by calling or emailing, or in person. **You cannot be reimbursed for driving yourself**.

Mileage reimbursement requires all of the following:

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

[*Plans may adjust contact information as appropriate when member calls vendor instead of plan.*] To ask for a ride for services that have been authorized, call <plan name> at [*insert plan's phone number and/or transportation provider's phone number*] at least [*insert plan's required advance notice in number of hours or business or calendar days*] (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

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

Non-medical transportation limits

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

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

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

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

H1. Care in a medical emergency

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

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- In the case of a pregnant woman in active labor, when:
    - There is not enough time to safely transfer you to another hospital before delivery.
    - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its

territories [*insert as applicable*: or worldwide], from any provider with an appropriate state license.

- [*Plans add if applicable:* **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else [*plans may replace "someone else" with "your care coordinator" or other applicable term*] should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us.] [*Plans must provide the contact phone number and days and hours of operation or explain where to find the information (e.g., on the back of the Member ID Card).*]

Covered services in a medical emergency

[*Plans that cover emergency medical care outside the United States or its territories through Medi-Cal may describe this coverage based on the Medi-Cal program coverage area. Plans must also include language emphasizing that Medicare does not provide coverage for emergency medical care outside the United States and its territories.*]

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook.*

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

[*Plans may add to this paragraph as needed to include other information about their post-stabilization care.*] Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

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

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

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

H2. Urgently needed care

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

Urgently needed care in our plan's service area

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

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

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

[*Plans must insert instructions for how to access urgently needed services (e.g., using urgent care centers, a provider hotline, etc.).*]

Urgently needed care outside our plan's service area

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

[*Plans that cover urgently needed care outside the United States or its territories through Medi-Cal may describe this coverage based on the Medi-Cal program coverage area.*]

Our plan does not cover urgently needed care or any other [*insert if plan covers emergency care outside of the United States and its territories:* non-emergency] care that you get outside the United States.

[*Insert if applicable: Plans with world-wide emergency/urgent coverage as a supplemental benefit:* Our plan covers worldwide [*Insert as applicable: emergency and urgently needed care OR emergency OR urgently needed care*] services outside the United States under the following circumstances [*insert details.*]]

H3. Care during a disaster

If the governor of California, the U.S. Secretary of Health and Human Services, or the president of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from our plan.

Visit our website for information on how to get care you need during a declared disaster: <web address>. [*In accordance with 42 CFR 422.100(m), plans must include on their web page, at a minimum, information about coverage of benefits at non-contracted facilities at network cost-sharing without required PA; terms and conditions of payment for non-contracted providers; and each declared disaster's start and end dates.*]

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at [*insert as applicable:* the in-network cost-sharing rate ***or*** no cost to you]. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Member Handbook* for more information.

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

[*Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medi-Cal-covered benefits.*]

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay [*plans with cost-sharing, insert:* our share of] the bill.

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

[*Insert as applicable*: If you paid for your covered services ***or*** If you paid more than your plan cost-sharing for covered services] or if you got a bill for [*plans with cost-sharing, insert:* the full cost of] covered medical services, refer to **Chapter 7** of your *Member Handbook* to find out what to do.

I1. What to do if our plan does not cover services

[*Plans with an arrangement with the state may add language to reflect that the organization is not allowed to reimburse members for Medi-Cal-covered benefits.*]

Our plan covers all services:

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

If you get services that our plan does not cover, **you pay the full cost yourself,** unless it is covered by another Medi-Cal program outside our plan.

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

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

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

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

J1. Definition of a clinical research study

[*If applicable, plans revise this section to describe Medi-Cal's role in providing coverage and payment for clinical research studies.*]

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

Once Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare, insert:* or our plan] approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

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

If you want to take part in any Medicare-approved clinical research study, you do **not** need to tell us or get approval from us [*plans that do not use PCPs may delete the rest of this sentence*] or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

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

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care coordinator to contact Member Services to let us know you will take part in a clinical trial.

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

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

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

[*Plans that conduct or cover clinical trials that are not approved by Medicare insert:* If you volunteer for a clinical research study, we pay any costs that Medicare does not approve but that our plan approves.] If you're part of a study that Medicare [*plans that conduct or cover clinical trials that are not approved by Medicare, insert:* or our plan] has **not** approved, you pay any costs for being in the study.

J3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

K1. Definition of a religious non-medical health care institution

[*If applicable, plans revise this section to describe Medi-Cal's role in providing care in religious non-medical health care institutions.*]

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

K2. Care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in a facility:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - [*Omit this bullet if not applicable*] You must get approval from us before you are admitted to the facility, or your stay will **not** be covered.

[*Plans must explain whether Medicare Inpatient Hospital coverage limits apply (include a reference to the Benefits Chart in Chapter 4* [*insert reference, as applicable*]*) or whether there is unlimited coverage for this benefit.*]

L. Durable medical equipment (DME)

L1. DME as a member of our plan

[*Plans may modify this section as directed by the state.*]

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you [*insert if the plan sometimes allows transfer of ownership to the member:* usually] will **not** own DME, no matter how long you rent it.

[*If the plan allows transfer of ownership of certain DME items to members, the plan must modify this section to explain the conditions and when the member can own specified DME.*]

[*If the plan sometimes allows transfer of ownership to the member for DME items other than prosthetics, insert:* In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.]

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

L2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You <Year>* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

If Medi-Cal is not elected, you will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or an MA plan

L3. Oxygen equipment benefits as a member of our plan

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

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

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

L4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

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

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

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

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

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

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.