THIS HANDBOOK BELONGS TO _____

CENTER_____

TELEPHONE NUMBER_____

ADDRESS_____

CENTER MANAGER_____

PHYSICIAN_____

SOCIAL WORKER_____

FOR 24 HOUR EMERGENCY SERVICES

ON-CALL PHYSICIAN TELEPHONE NUMBER _____

EMERGENCY TELEPHONE NUMBER 911

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

{PACE Program Name}

PARTICIPANT ENROLLMENT AGREEMENT

TERMS AND CONDITIONS
Effective {Date}

Table of Contents

CHAPTER ONE
WELCOME TO {PACE PROGRAM NAME}

{PACE Program} is a health care services plan designed just for people age 55 and older who have ongoing, complex health care needs. We are very pleased to welcome you as a Participant. Since we enroll only individuals, dependents are not covered when you enroll.

Please keep this booklet. Your signed copy of the {PACE Program} Enrollment Agreement form, along with these terms and conditions, will be your enrollment agreement, a legally binding contract between you and {PACE Program}.

This document should be read carefully and completely. Individuals with special health care needs should read carefully those sections that apply to them. You can find a Summary of Benefits and Coverage Table containing the major provisions of the {PACE Program} at the end of this chapter. {PACE Program} has an agreement with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) that is subject to renewal on a periodic basis, and if the agreements are not renewed the program will be terminated.

If you would like further information about the benefits of the {PACE Program}, please feel free to contact us at {PACE telephone number}. In this agreement, {PACE Program} is sometimes called "we" and you are sometimes called the "Participant." *Some of the terms used in this document may not be familiar to you. Please refer to the "Definitions" section in the back (Chapter Thirteen) for explanations of various terms used.*

Our philosophy at {PACE Program} is to help you remain as independent as possible, living in your own community and home. We offer a complete program of health and health-related services and focus on *preventive* measures to maintain your well-being.

One unique feature of {PACE Program) is our personal approach to health care and services. We make sure that you, your loved ones and our health care staff all know each other well, so we can work together effectively on your behalf. We do not want to replace the care of your family and friends. Rather, we hope to collaborate with you, your family and friends to provide the care you need. Your suggestions and comments are always encouraged and welcomed.

{PACE Program} operates 24 hours a day, seven days a week, 365 days a year. To treat the multiple chronic health care problems of our Participants, our health care professionals assess and evaluate changes, provide timely intervention and encourage Participants to help themselves. Based on your needs, we will provide medical, nursing and nutrition services; rehabilitation therapy; in-home services and training; pharmaceuticals; podiatry; audiology; and vision, dental and mental health services. On an inpatient basis, we provide acute and skilled nursing care in contracted facilities. (See CHAPTER FOUR for a more detailed description of covered benefits.)

Please examine this Contract carefully. Enrollment in the {PACE Program} is voluntary. If you are not interested in enrolling in our program, you may return the Contract to us without signing. If you do sign and enroll with us, your benefits under {PACE Program} will continue indefinitely unless you choose to disenroll from the program or you no longer meet the conditions of enrollment (See CHAPTER TEN for information on termination of benefits.)

Upon signing and enrolling in {PACE Program}, you will receive the following items:

- A copy of the Enrollment Agreement
- A copy of the {PACE Program} Participant Enrollment Agreement Terms and Conditions (this document)
- A {PACE Program} Membership card
- A sticker with our emergency telephone numbers to post in your home

Binding Neutral Arbitration

If we cannot reach an agreement, an arbitration process known as "binding neutral arbitration" will be used to settle any dispute, disagreement or claim you may have with respect to the benefits or care provided by {PACE Program}.

While under the care of {PACE Program}, you agree that except for disputes subject to a Medicare appeal procedure described in this document, any dispute, disagreement or claim that you have with {PACE Program} including any dispute as to medical malpractice (that is, as to whether any medical services rendered under this agreement were unnecessary or unauthorized or were improperly or incompetently rendered) will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to a court proceeding, except as California law provides for judicial review or arbitration proceedings.

Both parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. (For more detail, see CHAPTER TWELVE, under "Arbitration.")

Summary of Benefits and Coverage Table

The following table is intended to be used to help you compare coverage benefits and is a summary only. Please read this entire booklet, which constitutes your Contract with {PACE Program}, for a detailed description of coverage benefits and limitations.

Services must be either pre-approved or obtained from specified doctors, hospitals, pharmacies and other heath care providers who contract with {insert PACE Program}. However, prior authorization is never required for Emergency, Preventive, or Sensitive Services. Please refer to Chapter 4, PRINCIPAL BENEFITS AND COVERAGE.

CATEGORY	COPAYMENTS AND LIMITATIONS
Deductibles	None
Lifetime Maximums	None
Professional Services	• Physician services including primary care providers and medical specialists, routine physicals, preventive health evaluation, outpatient surgical services and outpatient mental health. **No Co-payments.** • Basic dental coverage (routine, preventive services including exam, X-rays and cleanings). Cosmetic dentistry is not included. **No Co-payments.** • Vision care. Prescription eyeglasses and corrective lenses after cataract surgery. **No Co-payments.** • Audiology services. Hearing exams and hearing aids. **No Co-payments.** • Routine podiatry. **No Co-payments.** • Medical social services/case management. **No Co-payments.** • Rehabilitation therapy. Includes physical, occupational and speech therapies. **No Co-payments.**

CATEGORY	CO-PAYMENTS AND LIMITATIONS
Outpatient Service	Coverage for surgical services, mental health, diagnostic X-ray and laboratory service. **No Co-payments.**
Hospitalization Services	Coverage for semi-private room and board and all medically necessary services including general medical and nursing services, psychiatric services, operating room fees, diagnostic or therapeutic services, laboratory services, X-ray, dressings, casts, anesthesia, blood and blood products, drugs and biologicals. Not covered are private rooms or private duty nursing, unless medically necessary, and non-medical items. **No Co-payments.**
Emergency Health Coverage	Coverage for emergency services. {PACE Program} does not cover emergency services outside the United States. **No Co-payments.**
Ambulance Services	**No Co-payments.**
Prescription Drug Coverage	Coverage for medications from the PACE organization formulary when prescribed by a physician. **No Co-payments.**
Durable Medical Equipment	**No Co-payments.**
Mental Health Services	**No Co-payments.**
Chemical Dependency Services	**No Co-payments.**

CATEGORY	CO-PAYMENTS AND LIMITATIONS
Home Health Services	**No Co-payments.**
Other	• Medicare covered skilled nursing facility. Coverage provided for semi-private rooms only. **No Co-payments.** • Home care services. **No Co-payments.** • Day center services (including nutrition, hot meals, escort and transportation). **No Co-payments.** • End of Life Care. **No Co-payments.** • Necessary materials, supplies and services for management of diabetes mellitus. **No Co-payments.**

CHAPTER TWO
SPECIAL FEATURES OF {PACE PROGRAM}

Our health care services plan has several unique features:

1. Expertise in Caring

Since {insert applicable year here}, {PACE Program} has specialized in caring for older people with serious health problems. Our successful approach focuses on developing customized care plans addressing specific health and health-related issues for each Participant. Our dedicated, highly skilled providers both plan and provide care, so the care you receive is comprehensive and coordinated.

2. The Interdisciplinary Team

Your care is planned and provided by a team of specialists, working together with you. Your team includes a Physician, possibly a Nurse Practitioner, Registered Nurses, a Home Care Nurse, Social Workers, Rehabilitation Therapists, a Dietician and others who assist you, such as Health Workers, Home Health Aides and Drivers of our vans. Each team member's special expertise is employed to assess your health care needs. Other staff may be called upon if necessary. Together they create a Plan of Care just for you.

3. Facilities

You probably will receive many of your health care services at our center—where your team will be. If you need transportation to come to the center, we will provide it. How often you come to the center will depend upon your treatment plan. {PACE Program} offers you access to medical care through our physicians and center on a 24-hour basis, 365 days of the year.

Our center is located at {insert address here}

4. Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR HEALTH CARE MAY BE OBTAINED. Because care is provided at {PACE Program} through an Interdisciplinary Team, the Primary Care Physician you choose will be a member of your Interdisciplinary Team. You will also be assigned the other providers on your team. Your Physician will be responsible for all of your primary health care needs and, with the help of the rest of your Interdisciplinary Team, will arrange for other medical services that you may need. (Some Participants also have a Nurse Practitioner who manages primary medical needs in consultation with the Primary Care Physician.) Participants have the option to seek gynecological physician services directly from a participating gynecologist.

When necessary, services may be provided in your home, a hospital or nursing home. We have contracts with physician consultants (such as cardiologists, urologists and orthopedists), pharmacies, laboratories and X-ray services, as well as with hospitals and nursing homes. Should you need such care, the staff on your team will continue working with you to monitor these services, your health and your ongoing needs.

If you wish to have the names, locations and hours of our contracting hospitals, nursing homes and other providers, you may request this information from the Contracts Administrator at {telephone #} or {TTY telephone # for the hearing impaired}.

5. Authorization and Management of Care

You will get to know each member of the team very well, for they will all work closely with you to help you remain as healthy and independent as possible. Before you can receive—or stop receiving—any service from {PACE Program}, the professionals on your team must approve it. However, prior authorization is never required for Emergency, Preventive, or Sensitive services.

At least every six months—more frequently if you are having problems—your team will assess your needs and adjust services if necessary. You and/or your family may also request an assessment. Your input and that of your family is necessary in this process. If your situation changes at any time, the team will adjust your services, based on your changing needs and their clinical judgment.

6. Medicare/Medi-Cal Relationship

The benefits under this Contract are made possible through an agreement which {PACE Program} has with Medicare (the Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (the California State Department of Health Care Services). When you sign this Contract, you are agreeing to accept benefits from {PACE Program}, in place of the usual Medicare and Medi-Cal benefits. {PACE Program} will provide services based on your needs (as determined by your Physician and the Interdisciplinary Team)—essentially the same benefits to which you are entitled under Medicare and Medi-Cal, plus many more.

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

7. No Pre-set Limits to Care

We are committed to providing you with appropriate care and we have no pre-set limit to service. For example, there is no restriction to the number of hospital or nursing home days that are covered if your {PACE Program} Physician determines that these are medically necessary. In-home care is also evaluated and provided by the team's clinical experts according to your need.

8. "Lock-in" Provision

Once enrolled with {PACE Program}, you agree to receive services ***exclusively*** from our organization, except in the case of an emergency, urgently needed services (including but not limited to renal dialysis services) and post-stabilization care covered out of network. You will have access to all the care you need through our staff or through arrangements that {PACE Program} makes with contract providers, but **you will no longer be able to obtain services from other doctors or medical providers under the traditional fee-for-service Medicare and Medi-Cal system.** (Please note that any services you use before your enrollment will not be paid for by {PACE Program} unless these are specifically authorized.)

CHAPTER THREE
ELIGIBILITY

You are eligible to enroll in {PACE Program} if you:

- Reside in {PACE Program's} service area, which includes {insert appropriate zip codes or other geographical parameters here}.
- Are 55 years of age or older.
- Require a skilled (SNF) or intermediate (ICF) level of nursing home care, as assessed by our Interdisciplinary Team. SNF means "Skilled Nursing Facility," a level-of-care designation of the need for continuous 24-hour availability of skilled nursing. ICF means "Intermediate Care Facility," a level-of-care designation of the need for 24-hour supervised care during the day on weekdays.
- Are able to live in the community without jeopardizing the health and safety of yourself and others.

You must also be:

- Certified by the State's Medi-Cal Field Office as having met these level-of-care requirements. Because {PACE Program} serves only older individuals who meet the State's level-of-care requirements for coverage of nursing facility services, an outside review must confirm that your health situation, in fact, qualifies you for our care.
- The State of California Medi-Cal Field Office provides this review after you sign the {PACE Program} Enrollment Agreement and after reviewing the documents prepared by the members of the Interdisciplinary Team who have assessed your health. In the very rare case that the Field Office finds that you are not qualified for the level of care provided by {PACE Program}, you will be required to disenroll. If that should happen, you will be reinstated in Medicare and Medi-Cal, provided your eligibility has not changed. Any fee you paid to {PACE Program} will be refunded to you.

CHAPTER FOUR
PRINCIPAL BENEFITS AND COVERAGE

Please see Chapter Five to learn how to receive care if you have a medical emergency or other urgent need for care.

What Do I Do if I Need Care?

All you need to do is call your center as listed on the inside cover of this booklet at any time.

Since we serve only older people who need ongoing care, our Plan provides you with ready access to a whole array of professionals and health care services. Upon enrollment you will know who your Primary Care Physician is, as well as the center where you will receive many of the services you need (and where the other members of your Interdisciplinary Team will see you).

All benefits are covered by {PACE Program} and will be provided according to your needs as assessed by the clinical experts on your Interdisciplinary Team, in accordance with professionally recognized standards. If you would like more specific information about how we authorize or deny health care services, please request this from your Social Worker.

Benefits include:

Services in the Center and the Community

- Primary care clinic visits (with {PACE Program} Physician, Nurse Practitioner and/or Nurse)
- Routine physicals and preventive health evaluations and care (including pap smears, mammograms, immunizations, and all generally accepted cancer screening tests). These services do not require prior authorization.
- Sensitive services, which are services related to sexually transmitted diseases and HIV testing. These services do not require prior authorization.
- Consultation with medical specialists

- Kidney dialysis
- Outpatient surgical services
- Outpatient mental health
- Medical social services/case management
- Health education and counseling
- Rehabilitation therapy (physical, occupational and speech)
- Personal care
- Recreational therapy
- Social and cultural activities
- Nutritional counseling and hot meals
- Transportation, including escort
- Ambulance service
- X-rays
- Laboratory procedures
- Emergency coverage anywhere in the United States
- Durable medical equipment: wheelchair, cane, walker and commode; hospital bed
- Prosthetic and orthotic appliances
- Routine podiatry
- Prescribed drugs and medicines
- Vision care (prescription eyeglasses, corrective lenses after cataract surgery)
- Hearing exams and hearing aids
- Dental care from the {PACE Program} dentist, with the goal of restoring Participant oral function to a condition which will help maintain optimal nutritional and health status. Dental services include Preventive Care (initial and yearly examinations, radiographs, prophylaxis and oral hygiene instructions); Basic Care (fillings and extractions); and Major Care (treatment which is determined by the condition of the mouth, for example, the amount of remaining supporting bone, the Participant's ability to comply with instruction, and the Participant's motivation to pursue oral health care). Major Care includes temporary crowns, full or partial dentures and root canals. Not included under dental care is: cosmetic dentistry.
- Diagnosis and treatment of male erectile dysfunction provided that the care is from {PACE Program} staff or a physician specialist under contract to {PACE Program}, and that such

care is deemed medically necessary. The Plan does not cover treatment, including medication, devices and surgery, which is deemed harmful to the Participant or which is deemed to be for cosmetic or recreational purposes and not medically necessary.
- Mastectomy, lumpectomy, lymph node dissection, prosthetic devices and reconstructive surgery.
- Necessary materials, supplies and services for the management of diabetes mellitus.

Home Services

- Home Care
    - Personal care (i.e., grooming, dressing, assistance in using the bathroom)
    - Homemaker/chore services
    - Rehabilitation maintenance
    - Evaluation of home environment

- Home Health
    - Skilled nursing services
    - Physician visits (at discretion of physician)
    - Medical social services
    - Home health aide service

Hospital Inpatient Care

- Semi-private room and board
- General medical and nursing services
- Psychiatric services
- Prescribed drugs, medicines and biologicals
- Diagnostic or therapeutic items and services
- Laboratory tests, X-rays and other diagnostic procedures
- Medical/Surgical, Intensive Care, Coronary Care Unit, as necessary
- Kidney dialysis
- Dressings, casts, supplies
- Operating room and recovery room
- Oxygen and anesthesia
- Organ and bone marrow transplants (non-experimental and non-investigative)

- Use of appliances, such as a wheelchair
- Rehabilitation services, such as physical, occupational, speech and respiratory therapy
- Radiation therapy
- Blood, blood plasma, blood factors and blood derivatives
- Medical social services and discharge planning

{PACE Program} does not cover private room and private duty nursing unless medically necessary, nor any non-medical items for which there is an additional charge, such as telephone charges or TV rental.

Skilled Nursing Facility

- Semi-private room and board
- Physician and nursing services
- Custodial care
- All meals
- Personal care and assistance
- Prescribed drugs and biologicals
- Necessary medical supplies and appliances, such as a wheelchair
- Physical, occupational, speech and respiratory therapy
- Medical social services

End of Life Care

{PACE Program's} comfort care program is available to care for the terminally ill. If needed, your Physician and other clinical experts on your Interdisciplinary Team will work with you and your family to provide these services directly or through contracts with local hospice providers. If you want to receive the Medicare hospice benefit, you will need to disenroll from our program to enroll with a Medicare-certified Hospice provider.

CHAPTER FIVE
EMERGENCY SERVICES AND URGENTLY NEEDED CARE

{PACE Program} provides emergency care 24 hours per day, 7 days per week, 365 days per year. An **Emergency Medical Condition** means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Serious jeopardy to the health of the Participant;
(2) Serious impairment to bodily functions;
(3) Serious dysfunction of any bodily organ or part.

Emergency Services include inpatient or outpatient services furnished immediately in or outside the service area because of an Emergency Medical Condition.

Call "911" if you reasonably believe that you have an Emergency Medical Condition which requires an emergency response and/or ambulance transport services. Shock, unconsciousness, difficulty breathing, symptoms of a heart attack, severe pain or a serious fall are all examples of Emergency Medical Conditions that require an emergency response.

After you have used the "911" emergency response system, you or your family must notify {PACE Program} as soon as reasonably possible in order to maximize the continuity of your medical care. {PACE Program} physicians who are familiar with your medical history will work with the emergency service providers in following up with your care and transferring your care to a {PACE Program} contracted provider when your medical condition is stabilized.

Preparing To Go Out of the {PACE Program} Service Area

Before you leave the {PACE Program} service area to go out of town, please notify your Interdisciplinary Team through your {PACE Program} Social Worker. Your Social Worker will explain what to do if you become ill while you are away from your {PACE Program} Physician. Make sure that you keep your membership card with you at all times, especially when traveling out of the service area. Your card identifies you as a {PACE Program} Participant and provides information to care providers (emergency rooms and hospitals) about your health care coverage and how to reach us, if necessary.

Emergencies and Urgently Needed Care When You Are Out of the Service Area

{PACE Program} covers both Emergency Services and Urgently Needed Care when you are temporarily out of our service area but still in the United States. **Urgently Needed Care** includes inpatient or outpatient services that are necessary to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

If you use Emergency Services or Urgently Needed Care when out of the service area (for example, ambulance or inpatient services), you must notify {PACE Program} within 48 hours or as soon as reasonably possible. If you are hospitalized, we have the right to arrange a transfer when your medical condition is stabilized, to a {PACE Program} contracted hospital or another hospital designated by us. We may also transfer your care to a {PACE Program} Physician.

{PACE Program} will pay for all medically necessary health care services provided to a Participant which are necessary to maintain the Participant's stabilized condition up to the time that {PACE Program} arranges the Participant's transfer or the Participant is discharged.

{PACE Program} must approve any routine medical services (i.e. medical services that do not constitute a medical emergency or other urgent need for care) when you are out of the service area. For authorization of any non-emergency, out-of-the-area services, you must call {PACE Program} at {include telephone # here} and speak with the Nurse or your Social Worker.

Reimbursement Provisions

If you have paid for Emergency Services or Urgently Needed Care you received when you were outside our service area but still in the United States, {PACE Program} will reimburse you. Request a receipt from the facility or physician involved at the time you pay. This receipt must show: the physician's name, your health problem, date of treatment and release, as well as charges. Please send a copy of this receipt to your {PACE Program} Social Worker within 30 working days.

Please note that if you receive any medical care or covered services as described in this document outside of the United States, {PACE Program} will not be responsible for the charges.

For Your Reference:

{PACE PROGRAM} EMERGENCY PLAN

POST IN A CONVENIENT PLACE

Date:

Participant's Name:

Physician's Name:

{PACE Program's} Day Health Center's Hours: {include business hours and days}

{PACE Program} Primary Care Physician: {Telephone and TTY #}

Health Care Wishes: DNR BLS Full Code

Before and after business hours and on weekends and holidays:

Call the {PACE Program} After-Hours Operator at {include telephone # here}. Say that you are a {PACE program} Participant and ask for an on-call nurse for:

_____

_____

_____

Call "911" in the event of an emergency.

Remember, an **emergency** is described as "a medical condition manifesting itself with symptoms of sufficient severity (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention would result in serious jeopardy to health, serious impairment of bodily functions or serious dysfunction of an organ or body part." Examples of emergencies include unconsciousness, severe bleeding, and/or extreme chest pain not relieved by your usual medications.

CHAPTER SIX
PRINCIPAL EXCLUSIONS AND LIMITATIONS ON BENEFITS

Please see Chapter Five to learn how to receive care if you have a medical emergency or other urgent need for care. Except for Emergency Services and Urgently Needed Care received outside our service area, Preventive, and Sensitive services, all care requires authorization in advance by the appropriate member of the Interdisciplinary Team.

The following general and specific exclusions are in addition to any exclusions or limitations described in Chapter Four for particular benefits.

Covered Benefits Do Not Include:

- Any service not authorized by the Physician or other qualified decision maker on the Interdisciplinary Team, even if it is listed as a covered benefit, with the exception of Emergency, Preventive, and Sensitive Services. If a {PACE Program} provider requests prior approval to provide you a health care service and the Team decision maker, Director or Medical Director denies, defers or modifies the request, you will be notified in writing of the reason for this denial and given information on how to exercise your right to appeal this decision, in accordance with California and federal law.

- Prescription drugs and over-the-counter drugs not prescribed by a {PACE Program} Physician except when prescribed as part of Emergency Services or Urgently Needed Care provided to you.

- Cosmetic surgery, unless the Physician on your Interdisciplinary Team determines that it is medically necessary for improved functioning of or to correct a malformed part of the body resulting from an accidental injury, trauma, infection, tumor or

disease, or to restore and achieve symmetry after a mastectomy.

- Experimental or investigational medical, surgical or other health procedures not generally available.
- Gender alteration procedures.
- Family planning, including sterilization operations or procedures.
- Care in a government hospital (VA, federal/state hospitals), except for Emergency Services and Urgently Needed Care.
- Services in any county hospital for the treatment of tuberculosis or chronic medically uncomplicated drug dependency or alcoholism.
- Short-Doyle/Medi-Cal Services
- In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the Interdisciplinary Team as part of your Plan of Care.
- Any services rendered outside the United States.
- The cost of labor and materials to modify your home environment, unless authorized by the Occupational Therapist and Physician on your Interdisciplinary Team.
- If you are out of {PACE Program} service area for more than 30 days, {PACE Program} may disenroll you unless other prior arrangements have been approved by the Director or Medical Director, upon recommendation of the Interdisciplinary Team.
- {PACE Program} will make every reasonable effort to provide a safe and secure environment at the center. However, we strongly advise Participants and their families to leave valuables at home. {PACE Program} is not responsible for safeguarding personal belongings.

CHAPTER SEVEN
YOUR RIGHTS AND RESPONSIBILITIES

{PACE Program} Participant Bill of Rights

At {PACE Program}, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each Participant by assuring the following rights:

Respect and Non-Discrimination

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care.

You have the right to:

- Be treated in a respectful manner that honors your dignity and privacy.
- Receive care from professionally trained staff.
- Know the names and responsibilities of the people providing your care.
- Know that decisions regarding your care will be made in an ethical manner.
- Receive comprehensive health care provided in a safe and clean environment and in an accessible manner.
- Be free from harm, including unnecessary physical or chemical restraints or isolation, excessive medication, physical or mental abuse or neglect, and hazardous procedures.
- Be encouraged to use your rights in the PACE program.
- Receive reasonable access to a telephone at the center, both to make and receive confidential calls, or to have such calls made for you if necessary.
- Not have to do work or services for the PACE program.
- Not be discriminated against in the delivery of PACE services based on race, ethnicity, national origin, religion, sex, age, mental or physical disabilities or source of payment.

Information Disclosure

You have the right to get accurate, easy-to-understand information and have someone help you make informed health care decisions.

You have the right to:

- Be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing participation in {PACE Program}.
- Be fully informed, in writing, of the services offered by {PACE Program}, including services provided by contractors instead of {PACE Program} staff. You must be given this information before enrollment, at enrollment, and when there is a change in providers/service.
- A full explanation of the Enrollment Agreement and an opportunity to discuss it.
- Have an interpreter or a bilingual provider available to you if your primary language is not English.
- Examine the results of the most recent federal or state review of {PACE Program} and how {PACE Program} plans to correct any problems that are found at inspection.

Confidentiality

You have the right to talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

You have the right to:

- Have all the information related to your care kept confidential within required regulations.
- Be assured that your written consent will be obtained for the release of medical or personal information or photographs or images to persons not otherwise authorized under law to receive it.
- Review and copy your medical records and request amendments to those records and have them explained to you.

- Be assured of confidentiality when accessing Sensitive Services such as Sexually Transmitted Disease (STD) and HIV testing.

Choosing Your Provider

You have the right to:

- Choose your own primary care provider and specialists from the {PACE Program} provider panel.
- Request a specialist for women's health services or preventive women's health services.
- Initiate the disenrollment process at any time giving 30-day notice.

Emergency Care

You have the right to:

- Receive health care services in an emergency without prior approval from the {PACE Program} Interdisciplinary Team.

Treatment Decisions

You have the right to:

- Participate in the development and implementation of your Plan of Care. A Participant may also designate a health spokesperson.
- Have all treatment options explained to you in a respectful manner and acknowledge this explanation in writing.
- Make your own health care decisions.
- Refuse treatment and be informed of the consequences.
- Request and receive complete information about your health and functional status by the {PACE Program} Interdisciplinary Team.
- Request a reassessment by the {PACE Program} Interdisciplinary Team.
- Receive reasonable advance notice, in writing, if you are to be transferred to another treatment setting for medical reasons or for your welfare or the welfare of other Participants. Any such actions will be documented in your health record.

- Have our staff explain Advance Health Care Directives to you and to establish one on your behalf, if you desire.

Exercising Your Rights

You have the right to:

- Assistance to exercise civil, legal and Participant rights, including {PACE Program} grievance process, the Medi-Cal fair hearing process and the Medicare and Medi-Cal appeals processes.
- Voice your complaints and recommend changes in policies and services to our staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
- Appeal any treatment decision made by {PACE Program} or our contractors through our appeals process and to have a fair hearing.

If you feel any of your rights have been violated or you are dissatisfied and want to file a grievance or an appeal, please report this immediately to your Social Worker or call our office during regular business hours at {telephone #} or our toll free line at {telephone #}.

Please refer to other sections of your {PACE Program} *Participant Enrollment Agreement Terms and Conditions* booklet for details about {PACE Provider} as your sole provider; a description of {PACE Program} services and how they are obtained; how you may obtain emergency and urgently needed services outside {PACE Program's} network; the grievance and appeals procedure; conditions for disenrollment; and a description of premiums, if any, and payment of these.

Participant Responsibilities

We believe that you and your caregiver play crucial roles in the delivery of your care. To assure that you remain as healthy and independent as possible, please establish an open line of

communication with those participating in your care and be accountable for the following responsibilities:

You have the responsibility to:

- Cooperate with the Interdisciplinary Team in implementing your Plan of Care.
- Accept the consequences of refusing treatment recommended by the Interdisciplinary Team.
- Provide the Interdisciplinary Team with a complete and accurate medical history.
- Utilize only those services authorized by {PACE Program}.
- Take all prescribed medications as directed.
- Call the {PACE Program} Physician for direction in an urgent situation.
- Notify {PACE Program} within 48 hours or as soon as reasonably possible if you require emergency services out of the service area.
- Notify {PACE Program} in writing when you wish to initiate the disenrollment process.
- Pay required monthly fees as appropriate.
- Treat our staff with respect and consideration.
- Not ask staff to perform tasks that they are prohibited from doing by PACE or agency regulations.
- Voice any concerns or dissatisfaction you may have with your care.

CHAPTER EIGHT
PARTICIPANT GRIEVANCE AND APPEALS PROCESS

All of us at {PACE Program} share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns, grievances or dissatisfaction you have so that we can address them. You also have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

The information in this chapter describes our grievance and appeals processes. You will receive written information of the grievance and appeals processes when you enroll and annually after that. At any time, should you wish to file a grievance or an appeal, we are available to assist you. A bilingual staff member or translation services person will be available to facilitate the process.

{PACE Program} staff will not discriminate against you because a grievance has been filed and will continue to provide you with all the required services during the grievance process. {PACE Program} will maintain confidentiality throughout the grievance process and release information only to authorized individuals.

Grievance Procedure

Definition: A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of participant care. You may also file a grievance if you believe that your Participant Rights have been violated. You may file a grievance yourself or your representative may file one on your behalf. If you are not satisfied with the outcome of your grievance, you have other grievance options.

Please follow this process:

1. Discuss your grievances with {insert appropriate contacts here, i.e. Social Worker, the Home Care Supervisor and/or the Center Manager}. This person will make sure that you receive written information on the grievance process and that your grievance is documented. Be sure to give complete information so the appropriate staff can help to resolve your grievance in a timely manner. If you wish to register a written grievance, please send it to: {Designated Individual; insert address here}.

   You may also contact {insert designated individual @ appropriate department, i.e. Quality Assurance Department} at {telephone #} [if applicable, add "or our toll-free number at {#}] to request a grievance form and receive assistance in filing a grievance. For the hearing impaired (TTY/TDD), please call [insert telephone number]. Our {insert designated individual} will provide you with written information on the grievance process. [If applicable, insert "You may also access our website at {insert website here} to receive information about the grievance process].

2. The staff member who receives the grievance will help you document your grievance (if your grievance is not already in writing) and coordinate investigation and action. ALL information gathered during the investigation will be kept confidential.

3. You will be sent a written confirmation of receipt within five calendar days of filing your grievance. We will investigate, find solutions and take appropriate action.

4. The staff will find a solution to your grievance within 30 calendar days of receipt of your grievance. If you are not satisfied with that resolution, you or your representative has the right to pursue further action.

5. If the grievance involves imminent and serious threat to your health, including, but not limited to potential loss of life, limb or major bodily function, severe pain or violation of your Participant Rights, we will expedite the review process to reach a decision within three days (72 hours) of receiving your written grievance and request for expedition. In this case, you will be informed immediately by telephone of: (a) the receipt of your request for expedited review, and (b) your right to notify the Department of Social Services (State Fair Hearing Process) of the grievance.

6. When the grievance is resolved, {indicate appropriate responder(s) here} will send you a report describing the problem's resolution, the basis for the resolution and the review process if you are still dissatisfied.

Grievance Review Options

If, after completing the grievance process, or after participating in the process for at least 30 calendar days, you or your representative is still dissatisfied, you may pursue further steps. Your grievance review options are:

1. If you are covered by Medi-Cal only or by Medi-Cal and Medicare, you are entitled to pursue your grievance with the California Department of Health Care Services, by writing to:

Ombudsman Unit
Medi-Cal Managed Care Division
California Department of Health Care Services
P.O. Box 997413, Mail Station 4412
Sacramento, CA 95899-7413
Telephone: 1-888-452-8609
TTY: 1-800-735-2922

State Fair Hearing Process: At any time during the grievance process, you may also request a fair hearing from the California Department of Social Services by contacting:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: (916) 229-4410
TTY: 1-800-952-8349

{If your organization holds a Home Health Agency license, then insert the following}:

Home Health Hotline: If you have a question or concern regarding {PACE Program's} home health services, we recommend that you first discuss the matter with your {insert appropriate contacts here, i.e. Home Health Nurse, Social Worker or Center Manager}. However, please be informed that the State of California has established a confidential toll-free telephone number to receive questions or complaints about home health services. The telephone number is: {insert applicable L&C Office (will vary depending on location) number and TYY/TDD number, as available}, Monday through Friday, from 9:00 a.m. to 5:00 p.m.

Appeals Process

Definition: An appeal is defined as an action taken by a Participant or Participant's representative regarding our organization's decision not to cover, or not to pay, for a service.

You will receive written information on the appeals process when you enroll and annually after that, as well as whenever {PACE Program} denies a request for services or payment.

You have the right to file an appeal if we deny your request for services or payment. You may file your appeal either verbally or in

writing. The reconsideration of our decision will be made by a person(s) not involved in the initial decision-making process. We will insure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services at issue. You or your authorized representative may present or submit relevant facts and/or evidence for review, either in person or by writing to us.

{PACE Program} will not discriminate against you or your designated representative because an appeal has been filed. {PACE Program} will maintain confidentiality throughout the appeals process and release information only to authorized individuals.

Note: For {PACE program} Participants enrolled in Medi-Cal—we will continue providing a service until the appeals process is finished. If our initial decision to not continue or reduce services is upheld, you will be financially responsible for the payment of disputed services provided during the appeals process.

Standard and Expedited Appeals Processes: There are two types of appeals processes: standard and expedited appeals processes. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within 180 calendar days of when your request for service or payment of service was denied. (The 180-day limit may be extended for good cause.) Within five calendar days of receiving your appeal, {PACE Program} will acknowledge in writing that the appeal has been received. We will issue a decision on your appeal as quickly as your health requires, but no later than 30 days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any physician may ask for an **expedited appeal**. If any doctor asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than 72 hours after we receive your request for an appeal. We

may extend this time frame up to 14 days if you ask for the extension or if we justify to the California Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a doctor, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an expedited appeal, we will let you know within 72 hours. If this happens, your appeal will be considered a standard appeal.

The Decision on Your Appeal:

If we decide fully in your favor on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than 30 calendar days from when we received your request for an appeal. **If we decide fully in your favor** on a request for **payment**, we are required to make the requested payment within 60 calendar days after receiving your request for an appeal.

If we do not decide fully in your favor on a **standard appeal**, or if we fail to provide you with a decision within 30 days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program **(see Additional Appeal Rights, below).** We also are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the federal Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will inform you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal on to the appropriate review.

If we decide fully in your favor on an **expedited appeal**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than 72 hours after we received your request for an appeal.

If we <u>do not</u> decide fully in your favor on an **<u>expedited appeal</u>** or fail to notify you within 72 hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We let you know you in writing of your appeal rights under Medicare or Medi-Cal managed care, or both. We will help you choose which to pursue if both are applicable. We are required to send your appeal on to the appropriate review.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program, or both.

The Medicare program contracts with an "independent review organization" to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The Medi-Cal program conducts their next level of appeal through the state's fair hearing process. If you are enrolled in Medi-Cal, you can appeal if we want to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive these services. However, you may have to pay for these services if the decision is not in your favor.

If you are enrolled in **both Medicare and Medi-Cal**, we will help you choose which appeals process you should follow. We also will send your appeal on to appropriate review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal processes are described below.

Medi-Cal External Appeals Process

If you receive **both Medi-Cal and Medicare OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal's external appeals process, we will send your appeal to the California Department of Social Services. You may request a fair hearing through:

California Department of Social Services
State Hearings Division
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430
Telephone: 1-800-952-5253
Fax: (916) 229-4410
TTY: 1-800-952-8349

Medicare External Appeals Process

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only**, you may choose to appeal using Medicare's external appeals process. We will send your appeal to Medicare's independent review organization for you. Medicare currently contracts with the Center for Health Dispute Resolution (CHDR) to impartially review appeals. CHDR will contact us with the results of their review. CHDR will either maintain our original decision or change our decision and rule in your favor.

Expedited and Standard Appeals Process:

You can request an ***expedited*** external appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited external review, we will send your appeal to CHDR as quickly as your health requires. CHDR must give us a decision within 72 hours after they receive the appeal. CHDR may ask for more time to review the appeal, but they must give us their decision within 14 calendar days.

If CHDR's decision is in your favor for an expedited appeal:
We must give permission for you to get the service or give you the service as quickly as your health condition requires.

You can request a ***standard*** external appeal if we deny your request for non-urgent services or do not pay for a service. For a standard external appeal, you receive a decision on your appeal no later than 30 calendar days after you request the appeal.

If CHDR's decision is in your favor for a standard appeal:
If you have requested a service that you have not received, we are required to give you the service you asked for as quickly as your health condition requires;

-OR-

If you have requested payment for a service that you have already received, we are required to pay for the service within 60 days.

If CHDR's decision is **not** in your favor for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

CHAPTER NINE
MONTHLY FEES

{PACE Program} sets its fees on an annual basis and has the right to change its fees with 30 days' written notice.

Prepayment Fees

Your payment responsibility will depend upon your eligibility for Medicare, Medi-Cal and Medi-Cal's Medically Needy Only (MNO) programs:

1. If you are eligible for Medi-Cal or a combination of Medi-Cal and Medicare, you will pay nothing to {PACE Program} for the benefits and services described in CHAPTER FOUR, including prescription drugs.

2. If you qualify for Medicare and Medi-Cal's Medically Needy Only (MNO) program, you will pay a monthly premium equal to your MNO share of cost responsibility.

3. If you are eligible only for Medicare, you will be charged a monthly premium. Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage. This monthly premium may be reduced if you qualify for a low-income subsidy.

4. If you are not eligible for Medi-Cal or Medicare, you will be charged the full monthly premium. This premium will include the cost of prescription drugs.

Please refer to your signed Enrollment Agreement for the amount you will be charged. If you have a monthly responsibility for payment of a premium or prescription drug coverage, the Enrollment Representative will explain this to you. We will also discuss your payment with you at the enrollment conference and write the amount on your Enrollment Agreement before you are asked to sign it. If

you are charged both premiums, you may pay them together or you may contact your Social Worker for additional payment options. We will notify you in writing of any change in your monthly premium at least 30 days before the change takes effect.

Your usual monthly Medicare Part B premium will continue to be deducted from your Social Security check.

Prescription Drug Coverage Late Enrollment Penalty

Please be aware that if you are eligible for Medicare prescription drug coverage and are enrolling in {PACE Program} after going without Medicare prescription coverage or coverage that was as least as good as Medicare drug coverage for 63 or more consecutive days, you may have to pay a higher monthly amount for Medicare prescription drug coverage. You may contact your {PACE Program} Social Worker for more information about whether this applies to you.

If you are required to pay a monthly premium or a premium for prescription drug coverage, you will receive an invoice. You must pay this amount by the first day of the month after you sign the Enrollment Agreement and on the first day of each subsequent month. Payment may be made by check or money order to:

{PACE Program address here}
Attention: Accounting Department

Late Charges

Monthly payments are due on the first day of each month. If you have not paid this premium by the tenth day of the month, you may be assessed a late fee of $20.00, in accordance with applicable law. Late fees do not apply to Participants with Medi-Cal coverage.

Termination for Non-Payment

If you pay a monthly premium, your monthly invoice will remind you that you are required to pay your monthly fee by the first day of each month. If you have not paid your monthly premium by the tenth day of the month, {PACE Program} may terminate your coverage. If this occurs, {PACE Program} will mail you a Cancellation Notice on the

tenth day of the month, informing you that your contract will be terminated if you still have not paid the amount due (the monthly premium and late charge) by the cancellation date given in the Cancellation Notice. The cancellation date will be at least fifteen (15) days after {PACE Program} mails you the Cancellation Notice. The Cancellation Notice will also inform you that, if you pay the required amount within a thirty (30) day grace period after {PACE Program} gives you the Cancellation Notice you will be reinstated with no break in coverage. You are obligated to pay the premium for any month in which you use {PACE Program} services. If your benefits are terminated and you wish to re-enroll, please refer to CHAPTERS TEN and ELEVEN regarding {PACE Program} termination policy and renewal provisions.

Other Charges: None. There are no co-payments or deductibles for authorized services.

CHAPTER TEN
COVERAGE AND TERMINATION OF BENEFITS

Your enrollment in {PACE Program} is effective the first day of the calendar month following the date you sign the "Enrollment Agreement." For example, if you sign the Enrollment Agreement on March 14, your enrollment will be effective on April 1.

- If you are eligible for Medi-Cal, your official enrollment with the Department of Health Care Services as a {PACE Program} Participant is subject to a 15 to 45-day enrollment processing period after the date you sign at {PACE Program}.

- If you are not certified by the State of California Medi-Cal Field Office as meeting the nursing home level of care requirements (see CHAPTER THREE), you will be required to disenroll. We will put you in touch with other resources that may be able to help you.

- If you do not meet the financial eligibility requirements for Medi-Cal, you may pay privately for your care (see CHAPTER NINE).

After signing the Enrollment Agreement, your benefits under {PACE Program} continue indefinitely unless you choose to disenroll from the program ("voluntary disenrollment") or you no longer meet the conditions of enrollment ("involuntary disenrollment"). Both types of termination require at least 30 days' written notice by either party. The effective date of termination is midnight of the last day of the month following the 30-day notice (except termination for failure to pay a required fee, see CHAPTER NINE).

You are required to continue to use {PACE Program's} services and to pay the monthly fee, if applicable, until termination becomes effective. At least 30-days' notice is needed to reinstate you into the traditional fee-for-service Medicare and Medi-Cal programs, but it can take up to 45 days before becoming effective. If you should require

care before your reinstatement occurs, {PACE program} will pay for the service to which you are entitled by Medicare or Medi-Cal.

Voluntary Disenrollment

If you wish to cancel your benefits by disenrolling, you should discuss this with your Social Worker. You may disenroll from {PACE Program} without cause at any time. You will need to sign a "Disenrollment Form" 30 days in advance of termination. This form will indicate that you will no longer be entitled to services through {PACE Program} after midnight on the last day of the month following the 30-day notice.

Involuntary Disenrollment

We may terminate your enrollment with {PACE Program} if:

- You move out of the {PACE Program} service area {include zip codes or other identifying information here} or are out of the service area for more than 30 days without prior approval (see CHAPTER SIX).

- You engage in disruptive or threatening behavior, i.e. your behavior jeopardizes the health or safety of yourself or others or you consistently refuse to comply with the terms of your Plan of Care or Enrollment Agreement, when you have decision-making capacity. Disenrollment under these circumstances is subject to prior approval by the California Department of Health Care Services and will be sought in the event that you, your friends or family members display disruptive interference or threatening behavior which interferes with the quality of PACE services provided to you and other PACE Participants.

- You are determined to no longer meet the Medi-Cal Nursing Home level of care criteria and are not deemed eligible.

- You fail to pay or fail to make satisfactory arrangements to pay any amount due to {PACE Program} within the 30-day period specified in any Cancellation Notice {see CHAPTER NINE).

- The agreement between {PACE Program}, the Centers for Medicare and Medicaid Services and the California State Department of Health Care Services is not renewed or is terminated.

- {PACE Program} is unable to offer health care services due to the loss of our State licenses or contracts with outside providers.

Both voluntary and involuntary disenrollments require a minimum 30 days' advance notice. All rights to benefits will stop at midnight on the last day of the month following the end of the 30-day notice period (except in the case of termination due to failure to pay fees owed, see CHAPTER NINE). We will coordinate the disenrollment date between Medicare and Medi-Cal, if you are eligible for both programs. You are required to use {PACE Program} services (except for Emergency Services and Urgently Needed Care provided outside our service area) until termination becomes effective.

If you are hospitalized or undergoing a course of treatment at the time your disenrollment becomes effective, {PACE Program} has the responsibility for service provision until you are reinstated with Medicare and Medi-Cal benefits (according to your entitlement and eligibility).

CHAPTER ELEVEN
RENEWAL PROVISIONS

Your coverage by {PACE Program} is continuous indefinitely (with no need for renewal). However, your coverage will be terminated if: (1) you fail to pay or fail to make satisfactory arrangements to pay any amount due {PACE Program} after the 30-day grace period (see CHAPTER NINE), (2) you voluntarily disenroll (see CHAPTER TEN), or (3) you are involuntarily disenrolled due to one of the other conditions specified in CHAPTER TEN.

If you choose to leave {PACE Program} ("disenroll voluntarily"), you may be re-enrolled. To be re-enrolled, you must reapply, meet the eligibility requirements and complete our assessment process.

If you are disenrolled due to failure to pay the monthly fee (see CHAPTER NINE), you can re-enroll simply by paying the monthly fee provided you make this payment before the end of the 30-day grace period (see CHAPTER NINE). In this case, you will be reinstated with no break in coverage.

CHAPTER TWELVE
GENERAL PROVISIONS

Arbitration

Except for disputes subject to a Medicare appeal procedure, any dispute, disagreement or claim that you have with {PACE Program}, including any dispute as to medical malpractice (that is, as to whether any medical services provided under this agreement were unnecessary, unauthorized or improperly or negligently or incompetently rendered) will be determined by submission to arbitration as provided by California law, and not by a lawsuit or court proceeding, except as California law provides for judicial review of arbitration proceedings. Both parties to this agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and are instead accepting the use of arbitration.

You may initiate arbitration by sending a letter titled "Demand for Arbitration," setting forth the specifics of your claim to:

{PACE Program address here}
Attention: Administration

If paying your portion of the neutral arbitrator's fees and expenses would cause you extreme hardship, you may request that {PACE Program} pay all or part of these costs. An independent neutral arbitrator will approve or deny your request for relief. {PACE Program} will pay the fees and expenses for this arbitrator, who will not be the same one who decides the underlying dispute.

Authorization to Obtain Medical Records

By accepting coverage under this contract, you authorize {PACE program} to obtain and use your medical records and information from any and all health care facilities and providers who have treated you in the past. This will include information and records concerning

treatment and care you received before the effective date of this contract.

Access to your own medical record is permitted in accordance with California law. This information will be stored in a secured manner that will protect your privacy and be kept for the time period required by law.

Authorization to Take and Use Photographs

By accepting coverage under this contract, you authorize {PACE Program} to make and use photographs, video tapes, digital or other images for the purpose of medical care, identification, payment for services or internal operation of {PACE Program}. Images will only be released or used outside {PACE Program} upon your authorization.

Changes to Contract

Changes to this Contract may be made if they are approved by the Centers for Medicare and Medicaid Services and the California State Department of Health Care Services. We will give you at least 30 day's advance written notice of any such change, and you will be deemed to have contractually agreed to such change.

Confidentiality of Medical Records Policy

The personal and medical information collected by {PACE Program} adheres to a confidentiality policy to prevent disclosure of your personal and medical information other than as needed for your care. You may request a copy of our confidentiality policy by calling {insert appropriate PACE Program designee and telephone # here}.

Continuation of Services on Termination

If this Contract terminates for any reason, you will be reinstated back into the traditional Medicare and Medi-Cal programs, according to your eligibility. Please be advised that this process can take from 30 to 90 days to become effective.

Cooperation in Assessments

So we can determine the best services for you, your full cooperation is required in providing medical and financial information to us.

Governing Law

Under federal law, {PACE Program} is subject to the requirements of the Balanced Budget Act of 1997 (P.L. 101-33) as amended and Sections 1894 and 1934 of the Social Security Act. Any provision required to be in this Contract by any of the above shall bind {PACE Program} whether or not set forth herein, and any provision of the Contract which, on its effective date, is in conflict with California or federal law is hereby amended to conform to the minimum requirements of such statutes.

No Assignment

You cannot assign any benefits or payments due under this Contract to any person, corporation or other organization. Any assignment by you will be void. (Assignment means the transfer to another person or organization of your right to services provided under this Contract or your right to collect money from us for those services.)

Nondiscrimination

{PACE Program} shall not unlawfully discriminate against Participants in the rendering of service on the basis of race, age, religion, color, national origin, ancestry, sex, marital status, sexual orientation or disability. {PACE Program} shall not discriminate against Participants in the provision of service on the basis of having or not having an Advance Health Care Directive.

Notice

Any notice which we give you under this Contract will be mailed to you at your address as it appears on our records. It is your responsibility to notify us promptly of any change to your address. When you give us any notice, please mail it to:

{PACE Program address here}
Attention: {contact person or department here}

Notice of Certain Events

If you may be materially and adversely affected, we shall give you reasonable notice of any termination, breach of contract or inability to perform by hospitals, physicians or any other person with whom we have a contract to provide services. We will give you 30 days written notice if we plan to terminate a contract with a medical group or individual practice association from whom you are receiving treatment. In addition, we will arrange for the provision of any interrupted service by another provider.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your {PACE Program} Primary Care Physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization helps coordinate the donation.

Our Relationship to {PACE Program} Providers

{PACE Program} providers other than {PACE program} staff are independent organizations and are related to us by contract only. These providers are not our employees or agents. {PACE Program} providers maintain a relationship with you and are solely responsible for any of their acts or omissions, including malpractice or negligence. Nothing in this Contract changes the obligation you have to any provider who renders care to you to abide by the rules, regulations and other policies established by the provider.

Participation in Public Policy of Plan

{NOTE: The following is a suggested structure only. Please modify as you see fit to best meet the needs of your organization.}

The Board of Directors of {PACE Program} has a standing committee, known as the {enter name of committee here}, which reports to the

board every quarter and advises the board on issues related to the actions of {PACE Program} and our staff to assure Participant comfort, dignity and convenience. The committee has nine members, at least five of whom are Participants enrolled in {PACE Program}. In addition, at least one committee member is a {PACE Program} board member and at least one committee member is a provider. All members of the committee are appointed by the board, but are nominated by the committee itself. The committee elects its own co-chairs, at least one of whom must be a Participant. Any material changes in our health care services plan are communicated to Participants at least annually.

Policies and Procedures Adopted by Us

We reserve the right to adopt reasonable policies and procedures to provide the services and benefits under this Contract.

Recovery from Third Party Liability

If you are injured or suffer an ailment or disease due to an act or omission of a third party giving rise to a claim of legal liability against the third party, {PACE Program} must report such instances to the California State Department of Health Care Services. If you are a Medi-Cal beneficiary, any proceeds which you collect, pursuant to the injury, ailment or disease, are assigned to the California State Department of Health Care Services.

Reduction of Benefits

We may not decrease in any manner the benefits stated in this Contract, except after a period of at least 30 days' written notice. The 30-day period will begin on the date postmarked on the envelope.

Reimbursement from Insurance

If you are covered by private or other insurance, including but not limited to motor vehicle, liability, health care or long-term care insurance, {PACE Program} is authorized to seek reimbursement from that insurance if it covers your injury, illness or condition. (Instances of tort liability of a third party are excluded.) We will directly bill these insurers for the services and benefits we provide

(and upon receipt of reimbursement reduce any payment responsibility you may have to {PACE Program}. You must cooperate and assist us by giving us information about your insurance and completing and signing all claim forms and other documents we need to bill the insurers. If you fail to do so, you, yourself, will have to make your full monthly payment. (See CHAPTER NINE for payment responsibility.)

Safety

To provide a safe environment, {PACE Program's} Safety Policy includes mandatory use of quick release wheelchair seat belts for all Participants while in transit, either in a vehicle or from one program area to another.

Second Opinion Policy

You may request a second medical opinion, as may others on your behalf, including your family, your Primary Care Physician and the Interdisciplinary Team. If you desire a second opinion you should notify your Primary Care Physician or Nurse Practitioner. {PACE Program} will issue a decision on second opinions within 72 hours. The timeline is available upon request by calling {insert phone # here} or contacting {insert name and address of appropriate entity here}.

Standing Referrals Process

You may receive a standing referral to a medical specialist if you have HIV or AIDS or if your Primary Care Physician determines that you need the continuing care of a specialist. Your Primary Care Physician is responsible for approving a standing referral and will do so in accordance with {PACE Program's} standing referral procedures. Additional information regarding standing referrals, including a list of specialists with expertise in caring for people with HIV or AIDS is available upon request by contacting your Primary Care Physician or {list additional contact person or place here} at {insert telephone # here}.

Time Limits on Claims

Any claim that you may have against {PACE Program} or with respect to services provided by {PACE Program} must be brought by you within two years from the date you receive the service for which the claim is brought. In the case of personal injuries, the claim must be brought within one year from the date on which those injuries were sustained.

Tuberculosis Testing

A tuberculosis skin test(s) or chest X-ray is required prior to enrollment.

Waiver of Conditions for Care

If you do not meet a certain condition of {PACE Program} to receive a particular service, we reserve the right to waive such a condition if we, in our judgment, determine that you could medically benefit from receiving that service. However, if we do waive a condition for you in one instance, this does not mean that we are obligated to waive that condition or any other condition for you on any other occasion.

Who Pays for Unauthorized Services?

You will be responsible to pay for unauthorized services, except for Emergency Services and Urgently Needed Care (see “Reimbursement Provisions” in CHAPTER FIVE).

Who Receives Payment Under this Contract?

Payment for services provided under this Contract will be made by {PACE Program} to the provider. You cannot be required to pay anything that is owed by {PACE Provider} to the selected providers.

CHAPTER THIRTEEN
DEFINITIONS

Benefits and coverage are the health and health-related services we provide through this Contract. These services take the place of the benefits you would otherwise receive through Medicare and/or Medi-Cal. Their provision is made possible through an agreement between {PACE Program}, Medicare (Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (State of California Department of Health Care Services). This Contract gives you the same benefits you would receive under Medicare and Medi-Cal plus many additional benefits. To receive any benefits under this Contract, you must meet the conditions described in this Contract.

Contract means the agreement between you and {PACE Program} which establishes the terms and conditions and describes the benefits available to you. This Contract remains in effect until Disenrollment and/or Termination take place.

Contracted provider means a health facility, health care professional or agency that has contracted with {PACE Program} to provide health and health-related services to {PACE Program} Participants.

Coverage decision means the approval or denial of health services by {PACE Program} substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of our contract with you.

Credentialed refers to the requirement that all practitioners (physicians, psychologists, dentists and podiatrists) who serve {PACE Program} Participants must undergo a formal process that includes

thorough background checks to verify their education, training and experience and confirm competence.

Department of Health Care Services (DHCS) means the single State Department responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California), California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health-related programs.

Designated representative means a spouse, significant other, child, relative, friend or someone else you choose to involve in your care.

Disputed health care service means any health care service eligible for payment under your Contract with {PACE Program} that has been denied, modified or delayed by a decision of {PACE Program} in whole or in part due to the finding that a service is not medically necessary. A decision regarding a "disputed health care service" relates to the practice of medicine and is not a coverage decision.

Eligible for nursing home care means that your health status, as evaluated by the {PACE Program} Interdisciplinary Team, meets the State of California's criteria for placement in either an Intermediate care facility (ICF), or a Skilled Nursing Facility (SNF). {PACE Program's} goal, however, is to help you to stay in the community as long as possible, even if you are eligible for nursing home care.

Emergency Medical Condition and **Emergency Services** are defined in CHAPTER FIVE.

Exclusion means any service or benefit that is not included in this Contract. For example, non-emergency services received without authorization from the {PACE Program's} Interdisciplinary Team of

qualified clinical professionals are excluded from coverage. You would have to pay for any unauthorized services.

Experimental and Investigational service means a service that is not seen as safe and effective treatment by generally accepted medical standards (even if it has been authorized by law for use in testing or other studies in humans); or has not been approved by the government to treat a condition.

Family means your spouse, "significant other," children and relatives; the definition of "family" may also be expanded to include close friends or any other person you choose to involve in your care.

Health services are services such as medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthopedic devices, nutritional counseling, nursing, social services, therapies, dentistry, optometry, podiatry and audiology. Health services may be provided in a {PACE Program} center or clinic, in your home, or in professional offices of contracted specialists or other providers, hospitals or nursing homes under contract with {PACE Program}.

Health-related services are those services which help {PACE Program} provide health services and enable you to maintain your independence. Such services include personal care, homemaker/chore service, attendant care, recreational therapy, escorts, translation, transportation, home-delivered meals and assistance with housing problems.

Home health care refers to two categories of services—supportive and skilled services. Based on individualized Plans of Care, supportive services are provided to Participants in their homes and may include household services and related chores such as laundering, meal assistance, cleaning and shopping, as well as assistance with bathing and dressing as needed. Skilled services may be provided by the program's Social Workers, Nurses, Occupational Therapists and on-call medical staff.

Hospital services are those services which are generally and customarily provided by acute general hospitals.

Interdisciplinary Team means {PACE Program's} team of service providers, facilitated by a Center Manager, and consisting of a Primary Care Physician, Registered Nurse(s), Master's-level Social Worker (MSW), Personal Care Attendant, Home Care Coordinator, Driver, Physical, Recreational and Occupational Therapists and a Dietitian. {Note: The preceding list includes required, core members. Please insert any additional members.} Members of the Interdisciplinary Team will assess your medical, functional and psychosocial status and develop a Plan of Care which identifies the services needed. Many of the services are provided and monitored by this team. All services you receive must be authorized by your Physician or other qualified clinical professionals on the Interdisciplinary Team. Periodic reassessment of your needs will be done by the team and changes in your treatment plan may occur.

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted.

Medically necessary means medical or surgical treatments provided to a Participant by a participating provider of the Plan which are: (a) appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury; (b) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment; and (c) not for the convenience of a Participant or a participating provider of the Plan.

Monthly fee means the amount you must pay each month in advance to {PACE Program} to receive benefits under this Contract.

Nursing home means a health facility licensed as either an Intermediate Care Facility or a Skilled Nursing Facility by the California State Department of Health Care Services.

Out-of-area is any area beyond {PACE Program's} service area {insert appropriate zip codes or other geographic parameters here.}

PACE is the acronym for the **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly. PACE is the comprehensive service plan which integrates acute and long-term care for older people with serious health problems. Payments for services are on a monthly capitation basis, combining both state and federal dollars through Medicare and Medi-Cal. Individuals not eligible for these programs pay privately. PACE arranges for Participants to come to the {PACE Program} Center to receive individualized care from doctors, nurses and other health and social service providers. The goal is to help Participants stay independent in the community for as long as safely possible.

{PACE Program} Physician is a doctor who is either employed by {PACE Program} or has a contract with {PACE Program} to provide medical services to Participants.

Sensitive Services means those services related to sexually transmitted diseases (STD's) and HIV testing.

Service area means the geographical location that {PACE Program} serves. This area includes {insert appropriate zip codes or other geographic parameters here.}

Urgently Needed Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (for example, sore throats, fever, minor lacerations and some broken bones). Urgently Needed Care includes inpatient or outpatient services from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

APPENDIX I

This Appendix explains your rights to make health care decisions and how you can plan what should be done in the event that you cannot speak for yourself. A federal law requires us to give you this information. We hope this information will help increase your control over the medical treatment you receive.

Who Decides About My Treatment?

Your doctors will give you information and advice about treatment. You have the right to choose. You may say "Yes" to treatments you want. You may say "No" to treatments you don't want. You are entitled to say "No" to a treatment you don't want even if that treatment might keep you alive longer. If you have a conservator, you still may make your own health care decisions. This only changes if and when a judge decides that your conservator will also make your health care decisions on your behalf.

How Do I Know What I Want?

Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have "side effects." Your doctor must offer you information about serious problems that medical treatment may cause.

Often, more than one treatment might help you—and people have different ideas about which is best. Your doctor can tell you which treatments are available to you and which treatments may be most effective for you. Your doctor can also discuss whether the benefits of treatment are likely to outweigh potential drawbacks. However, your doctor can't choose for you. That choice depends on what is important to you.

What If I'm Too Sick To Decide?

If you are unable to make treatment decisions, your doctor will ask your closest available relative, friend or the person you have personally identified to the doctor as the one you want to speak for you to help decide what is best for you. That works most of the time. But sometimes everyone doesn't agree about what you want

to happen if you can't speak for yourself. There are several ways you can prepare in advance for someone you choose to speak for you. Under California Law, these are called Advance Health Care Directives.

An Advance Health Care Directive lets you write down the name of the person you want to make health care decisions for you when you can't. This part of an Advance Health Care Directive is called a Durable Power of Attorney for Health Care. The person you choose is called the "agent." There are Advance Health Care Directive forms you can use, or you can write down your own version as long as you follow a few basic guidelines.

Who Can Write An Advance Health Care Directive?

You can if you are 18 or older and of sound mind. You do not need a lawyer to make or fill out an Advance Health Care Directive.

Who Can I Name To Make Medical Treatment Decisions When I'm Unable To Do So?

When you make your Advance Health Care Directive, you can choose an adult relative or friend whom you trust. That person will then be able to speak for you in the event that you're too sick to make your own decisions.

How Does This Person Know What I Would Want?

Talk to the family member or friend whom you are considering to be your agent about what you would want. Make sure they feel comfortable with your wishes and able to carry them out on your behalf. You may write down your treatment wishes in the Advance Health Care Directive. You may include when you would or wouldn't want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. Take a copy with you when you go into a hospital or other treatment facility.

Sometimes treatment decisions are hard to make and it truly helps your family and doctors if they know what you want. The Advance

Health Care Directive also gives your health care team legal protection when they follow your decisions.

What If I Don't Have Anybody To Make Decisions For Me?

If you do not want to pick someone, or don't have anybody to name as your agent, you may just write down your wishes about treatment. This is still an Advance Health Care Directive. There is a place on the standard form to write your wishes, or you may write them on your own piece of paper. If you use the form, simply leave the Power of Attorney for Health Care section blank.

Writing down your wishes this way tells your doctor what to do in the event that you can no longer speak for yourself. You may write that you don't want any treatment that would only prolong your dying or you may write that you *do* want life-prolonging care. You may provide more detail about the type and timing of the treatment you would want. (Whatever you write, you would still receive care to keep you comfortable.)

The doctor must follow your wishes about your treatment unless you have requested something illegal or against accepted medical standards. If your doctor does not want to follow your wishes for another reason, your doctor must turn your care over to another doctor who will follow your wishes. Your doctors are also legally protected when they follow your wishes.

May I Just Tell My Doctor Who I Want Making Decisions For Me?

Yes, as long as you personally tell your doctor the name of the person you want making these health care decisions. Your doctor will write what you said in your medical chart. The person you named will be called your "surrogate." Your surrogate will be able to make decisions based on your treatment wishes, but only for 60 days or until your specific treatment is done.

What If I Change My Mind?

You may change your mind or revoke your Advance Health Care Directive at any time as long as you communicate your wishes.

Do I Have To Fill Out One Of These Forms?

No, you don't have to fill out any of these forms if you don't want to. You may just talk to your doctors and ask them to write down in your medical chart what you've said. And you may talk with your family. But people will be clearer about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

Will I Still Be Treated If I Don't Fill Out These Forms Or Don't Talk To My Doctor About What I Want?

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make medical decisions, someone else will have to make them for you. Remember that:

- A Durable Power of Attorney For Health Care lets you name someone to make treatment decisions for you. That person can make most medical decisions—not just those about life-sustaining treatment—when you can't speak for yourself.

- If you don't have someone you want to name to make decisions when you can't, you may also use an Advance Health Care Directive to just say when you would and would not want particular types of treatment.

- If you already have a "Living Will" or Durable Power of Attorney for Health Care, it is still legal and you do not need to make a new Advance Health Care Directive unless you wish to do so.