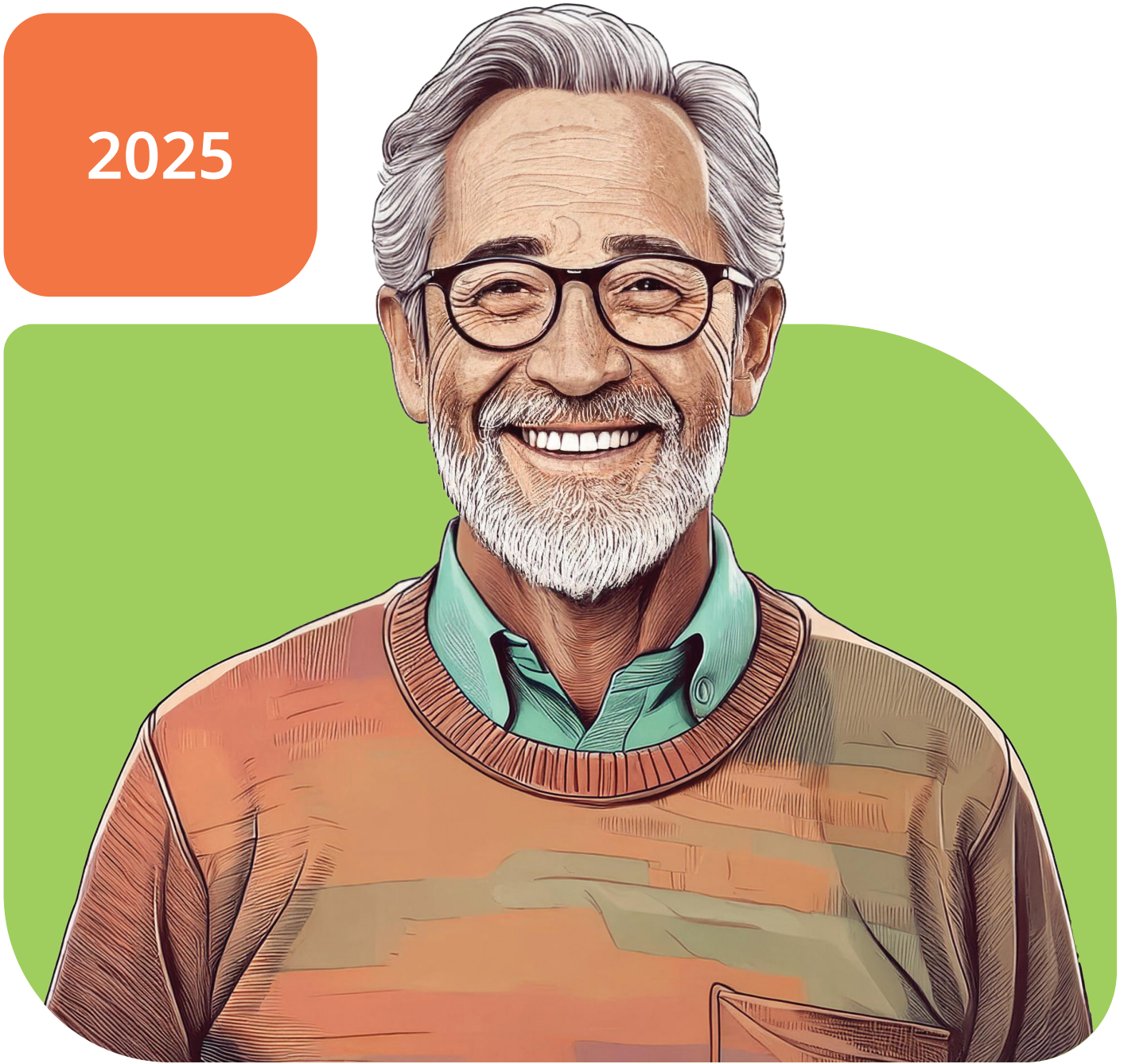


2025



# Member Handbook

CalOptima Health OneCare Flex Plus (H5433-003)

(HMO D-SNP), a Medicare Medi-Cal Plan

## CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan *Member Handbook*

January 1, 2025 – December 31, 2025

### Your Health and Drug Coverage under CalOptima Health OneCare Flex Plus

#### ***Member Handbook Introduction***

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through December 31, 2025. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means CalOptima Health OneCare Flex Plus.

This document is available for free in Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Customer Service at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free.

You can also make a standing request to get materials in other languages and/or alternate format:

- Other documents are available in English, Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic.
- Alternate formats available are large print, braille, data CD, or audio.
- Your standing request will be kept in our system for all future mailings and communications.
- To cancel or make a change to your standing request please call **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free.

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OMB Approval 0938-1444 (Expires: June 30, 2026)



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## Notice of Availability

### English

ATTENTION: If you need help in your language, call **1-877-412-2734 (TTY 711)**. Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-877-412-2734 (TTY 711)**. These services are free.

### Arabic

تنبيه: إذا كنت بحاجة إلى مساعدة في لغتك، اتصل بالرقم **1-877-412-2734 (TTY 711)** تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة برايل والطباعة الكبيرة. اتصل بالرقم **1-877-412-2734 (TTY 711)** هذه الخدمات مجانية.

### Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե Ձեր լեզվով օգնության կարիք ունեք, զանգահարեք **1-877-412-2734 (TTY' 711)** հեռախոսահամարով: Հաշմանդամ մարդկանց տրամադրվող աջակցությունները և ծառայությունները, ինչպիսիք են բրայլյան այբուբենով և խոշոր տպագիր փաստաթղթերը, նույնպես հասանելի են: Զանգահարեք **1-877-412-2734 (TTY' 711)** հեռախոսահամարով: Այս ծառայություններն անվճար են:

### Chinese Simplified

注意: 如果您需要以您的语言获得帮助, 请致电 **1-877-412-2734 (TTY 711)**。也为残障人士提供帮助和服务, 例如盲文和大字体的文件。请致电**1-877-412-2734 (TTY 711)**。这些服务是免费的。



If you have questions, please call CalOptima Health Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## Chinese Traditional

注意: 如果您需要以您的語言獲得幫助, 請致電 **1-877-412-2734** (TTY 711)。也為殘障人士提供幫助和服務, 例如盲文和大字體的文件。請致電 **1-877-412-2734** (TTY 711)。這些服務是免費的。

## Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਇੱਥੇ ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY 711)। ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬਰੇਲ ਅਤੇ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਦਸਤਾਵੇਜ਼ ਵੀ ਉਪਲਬਧ ਹਨ। ਕਾਲ ਕਰੋ **1-877-412-2734** (TTY 711)। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

## Hindi

ध्यान दें: अगर आपको हिन्दी भाषा में सहायता चाहिए, तो **1-877-412-2734** (TTY 711) पर कॉल करें। विकलांगता वाले लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज़ जैसी सहायताएं और सेवाएं भी उपलब्ध हैं। **1-877-412-2734** (TTY 711) पर कॉल करें। ये सेवाएं मुफ़्त हैं।

## Hmong

CEEB TOOM: Yog tias koj xav tau kev pab ua yog lus Hmong, hu rau **1-877-412-2734** (TTY 711). Cov kev pab thiab kev pabcuam rau cov neeg tsis taus, zoo li cov ntaub ntawv nyob rau hauv daim ntawv Braille thiab luam ntawv loj, kuj muaj. Hu rau **1-877-412-2734** (TTY 711). Cov kev pab cuam no pub dawb.

## Japanese

注: お客様の言語でのお手伝いが必要な場合は、**1-877-412-2734** (TTY 711) までお電話ください。障害をお持ちの方のために、点字や大きな文字での文書など支援とサービスをご用意しています。**1-877-412-2734** (TTY 711) までお電話ください。これらのサービスは無料でご利用いただけます。



If you have questions, please call CalOptima Health Flex Plus at **1-877-412-2734** (TTY 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



## Korean

주의: 귀하의 언어로 도움이 필요하시면 번호 **1-877-412-2734** (TTY **711**)번으로 전화하십시오. 점자 및 큰 글자 문서와 같은 장애인을 위한 지원 및 서비스도 제공됩니다. 번호 **1-877-412-2734** (TTY **711**)번으로 전화하십시오. 이 서비스는 무료입니다.

## Laotian

ການເອົາໃຈໃສ່: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາລາວ, ໂທຫາ **1-877-412-2734** (TTY **711**). ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນນູນ ແລະ ເປັນຕົວພິມໃຫຍ່, ແມ່ນຍັງມີຢູ່. ໂທຫາ **1-877-412-2734** (TTY **711**). ການບໍລິການແມ່ນບໍ່ເສຍຄ່າ.

## Mien

CAU FIM JANGX LONGX: Se gorngv meih qiex longc mienh tengx faan benx meih nyei waac, douc waac lorz taux **1-877-412-2734** (TTY **711**). Ninh mbuo mbenc duqv maaih jaa-dorngx aengx caux gong-bou jau-louc tengx ziux goux waaic fangx mienh, dorh sou zoux benx braille, nqaapv bieqc domh zei-linh. Douc waac lorz taux **1-877-412-2734** (TTY **711**). Naaiv deix gong-bou jau-louc benx wangv-henh tengx hhangv oc.

## Mon-Khmer, Cambodian

ប្រុងស្មារតី៖ បើអ្នកត្រូវការជំនួយជាភាសាខ្មែរ ទូរស័ព្ទទៅ លេខ **1-877-412-2734** (TTY **711**)។ ជំនួយ និងសេវាសម្រាប់មនុស្សដែលពិការ ដូចជាឯកសារនៅក្នុង អក្សរព្រិល និង អក្សរពុម្ពធំៗ ក៏មានផងដែរ។ ទូរស័ព្ទទៅ លេខ **1-877-412-2734** (TTY **711**)។ សេវាទាំងនេះមិនគិតថ្លៃទេ។



**If you have questions**, please call CalOptima Health Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## Persian (Farsi)

توجه: اگر به زبان خود نیاز به کمک دارید، با شماره **1-877-412-2734** (TTY 711) تماس بگیرید. کمک‌ها و خدمات برای افراد دارای معلولیت، مانند مطالب با خط بریل و چاپ بزرگ نیز در دسترس است. شماره تماس **1-877-412-2734** (TTY 711). این خدمات رایگان هستند.

## Russian

ВНИМАНИЕ. Если вы хотите получить поддержку на своем языке, звоните по тел. **1-877-412-2734** (TTY 711). Также доступны вспомогательные устройства и услуги для людей с ограниченными возможностями, например, документы, напечатанные шрифтом Брайля или крупным шрифтом. Обращайтесь по тел. **1-877-412-2734** (TTY 711). Услуги предоставляются бесплатно.

## Spanish

ATENCIÓN: Si necesita ayuda en su idioma, llame al **1-877-412-2734** (TTY 711). También se encuentran disponibles ayudas y servicios para personas con discapacidades, como documentos en braille y letra grande. Llame al **1-877-412-2734** (TTY 711). Estos servicios son gratuitos.

## Tagalog

ATENSYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa **1-877-412-2734** (TTY 711). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, tulad ng mga dokumentong nasa braille at malaking print. Tumawag sa **1-877-412-2734** (TTY 711). Libre ang mga serbisyong ito.



**If you have questions**, please call CalOptima Health Flex Plus at **1-877-412-2734** (TTY 711), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## Thai

โปรดทราบ: หากคุณต้องการความช่วยเหลือในภาษาของคุณ ให้โทรศัพท์ไปที่ **1-877-412-2734 (TTY 711)** การให้ความช่วยเหลือและบริการต่าง ๆ สำหรับผู้พิการ เช่น เอกสารในภาษาเบรลล์และเอกสารที่มีตัวพิมพ์ขนาดใหญ่ ยังมีให้บริการ โทรศัพท์ **1-877-412-2734 (TTY 711)** บริการเหล่านี้ไม่มีค่าใช้จ่าย

## Ukrainian

УВАГА! Якщо вам потрібна допомога вашою мовою, зателефонуйте на номер **1-877-412-2734 (телетайп 711)**. Доступні допоміжні засоби й послуги для людей з обмеженими можливостями, зокрема документація, надрукована шрифтом Брайля, а також із великим розміром тексту. Телефонуйте на номер **1-877-412-2734 (телетайп 711)**. Ці послуги надаються безкоштовно.

## Vietnamese

XIN LƯU Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, xin gọi số **1-877-412-2734 (TTY 711)**. Chúng tôi cũng trợ giúp và cung cấp dịch vụ cho người khuyết tật, như tài liệu bằng chữ nổi braille và chữ in khổ lớn. Xin gọi số **1-877-412-2734 (TTY 711)**. Những dịch vụ này đều miễn phí.

## Gujarati

ધ્યાન આપો: જો આપ ગુજરાતીમાં સહાયતા ઈચ્છો છો તો, કોલ કરો **1-877-412-2734 (TTY 711)**. વિકલાંગ વ્યક્તિઓ માટે મદદ અને સેવા, જેમ કે બ્રેઈલમાં દસ્તાવેજો અને મોટા અક્ષરની પ્રિન્ટ, પણ ઉપલબ્ધ છે. કોલ કરો **1-877-412-2734 (TTY 711)**. આ સેવાઓ મફત છે.



If you have questions, please call CalOptima Health Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

### Portuguese

ATENÇÃO: Se você precisa de ajuda no seu idioma, ligue para **1-877-412-2734 (TTY 711)**. Estão disponíveis também auxílio e serviços (documentos em braile ou impressão grande) para pessoas com deficiências. Ligue para **1-877-412-2734 (TTY 711)**. Todos esses serviços são gratuitos.

### Romanian

ATENȚIE: Dacă aveți nevoie de ajutor în limba dumneavoastră, sunați la **1-877-412-2734 (TTY 711)**. Pentru persoanele cu dizabilități sunt disponibile diferite facilități și servicii, precum documente în Braille și în format mare. Sunați la **1-877-412-2734 (TTY 711)**. Aceste servicii sunt gratuite.

### Turkish

DİKKAT: Kendi dilinizde yardım almak için **1-877-412-2734 (TTY 711)** numaralı telefonu arayabilirsiniz. Engelli bireyler için Braille alfabesi ve büyük punto ile yazılmış belgeler gibi yardım ve hizmetlerimiz bulunmaktadır. **1-877-412-2734 (TTY 711)** numaralı telefonu arayabilirsiniz. Bu hizmetler ücretsizdir.

### Urdu

توجہ: اگر آپ کو اردو میں مدد چاہیے تو، **1-877-412-2734 (TTY 711)**۔  
معذور افراد کے لیے امداد اور خدمات، جیسے بریل اور بڑے پرنٹ میں  
دستاویزات، بھی دستیاب ہیں۔ **1-877-412-2734 (TTY 711)** پر کال کریں۔  
یہ خدمات مفت ہیں۔



If you have questions, please call CalOptima Health Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



## Other languages

You can get this *Member Handbook* and other plan materials in other languages at no cost to you. CalOptima Health OneCare Flex Plus provides written translations from qualified translators. Call CalOptima Health OneCare Flex Plus Customer Service number at **1-877-412-2734** (TTY **711**). The call is free. Refer to your *Member Handbook* to learn more about health care language assistance services such as interpreter and translation services.

## Other formats

You can get this information in other formats such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call CalOptima Health OneCare Flex Plus Customer Service number at **1-877-412-2734** (TTY **711**). The call is free.

## Interpreter services

CalOptima Health OneCare Flex Plus provides oral interpretation services, including sign language, from a qualified interpreter, on a 24-hour basis, at no cost to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters unless it is an emergency. Interpreter, linguistic, and cultural services are available for free. Help is available 24 hours a day, 7 days a week. For help in your language, or to get this *Member Handbook* in a different language, call CalOptima Health OneCare Flex Plus Customer Service number at **1-877-412-2734** (TTY **711**). The call is free.



**If you have questions**, please call CalOptima Health Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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## Disclaimers

- ❖ CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, is a Medicare Advantage organization with Medicare and Medi-Cal contracts. Enrollment in CalOptima Health OneCare depends on contract renewal. CalOptima Health OneCare complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Call CalOptima Health OneCare Customer Service toll-free at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. Visit us at **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.
- ❖ The CalOptima Health OneCare Flex Plus grocery benefit is part of a special supplemental program for the chronically ill. Not all members qualify. To use the grocery benefit, CalOptima Health OneCare Flex Plus members must have one or more comorbid and medically complex chronic conditions that are life threatening or significantly limits the overall health or function of the enrollee. Eligible conditions include but are not limited to cardiovascular disorder, diabetes mellitus, chronic heart failure, chronic lung disease, or end-stage renal disease. Even if the member has a chronic condition, the member will not necessarily receive the grocery benefit. Receiving the grocery benefit depends on the member having a high risk of hospitalization or other adverse health outcomes and a need for intensive care coordination.
- ❖ Coverage under CalOptima Health OneCare Flex Plus is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at [www.irs.gov/Affordable-Care-Act/Individuals-and-Families](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families) for more information on the individual shared responsibility requirement.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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

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### **Introduction**

This chapter includes information about CalOptima Health OneCare Flex Plus, a health plan that covers all of your Medicare services and coordinates all of your Medicare and Medi-Cal services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

Chapter 1: Getting started as a member

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 1: Getting started as a member

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### A. Welcome to our plan

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

As a CalOptima Health OneCare Flex Plus member, you have access to one of the largest provider networks in Orange County. This means you get access to more hospitals, doctors and specialists. CalOptima Health OneCare Flex Plus coordinates your Medicare and Medi-Cal benefits through one single plan.

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### B. Information about Medicare and Medi-Cal

#### B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

#### B2. Medi-Cal

Medi-Cal is the name of California's Medicaid program. Medi-Cal is run by the state and is paid for by the state and the federal government. Medi-Cal helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

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

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

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

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

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

### **C. Advantages of our plan**

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

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

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

**New members to CalOptima Health OneCare Flex Plus:** In most instances you will be enrolled in CalOptima Health OneCare Flex Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in CalOptima Health OneCare Flex Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through CalOptima Health OneCare Flex Plus. There will be no gap in your Medi-Cal coverage. Please call us at **1-877-412-2734 (TTY 711)** if you have any questions.

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### **D. Our plan's service area**

Our service area includes Orange County, California.

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

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

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

You are eligible for our plan as long as you:

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

If you lose Medi-Cal eligibility but can be expected to regain it within six (6) months, then you are still eligible for our plan.

Call Customer Service for more information.

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

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

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

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

We'll send you more information about this HRA.

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

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
  - We determine an existing relationship by reviewing your available health information or information you give us.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 1: Getting started as a member

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- We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. You can make this request by calling **1-877-412-2734** (TTY **711**). If you are at risk of harm, we must respond within 3 days.
- You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

**Note:** You can make this request for providers of Durable Medical Equipment (DME) for at least 90 days until we authorize a new rental and have a network provider deliver the rental. Although you cannot make this request for providers of transportation or other ancillary providers, you can make a request for services of transportation or other ancillary services not included in our plan.

After the continuity of care period ends, you will need to use doctors and other providers in the CalOptima Health OneCare Flex Plus network that are affiliated with your primary care provider's health network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. A health network is a group of doctors and hospitals that contracts with CalOptima Health OneCare Flex Plus to provide covered services to our members. Refer to **Chapter 3** of your *Member Handbook* for more information on getting care.

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## G. Your care team and care plan

### G1. Care team

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## **G2. Care plan**

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

Your care plan includes:

- a written plan of care developed after an assessment of a your social and health care needs that reflects what services you will receive to reach and keep your best physical, mental, and social wellbeing.
- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

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## **H. Your monthly costs for CalOptima Health OneCare Flex Plus**

Our plan has no premium.

### **H1. Medicare Prescription Payment Amount**

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

**Chapter 2** tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in **Chapter 9** to make a complaint or appeal.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 1: Getting started as a member

### I. Your Member Handbook

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

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

The contract is in effect for the months you are enrolled in our plan between January 1, 2025 and December 31, 2025.

### J. Other important information you get from us

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

#### J1. Your Member ID Card

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



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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 1: Getting started as a member

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

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

- **Medi-Cal Dental Services**
  - Medi-Cal dental services (through the Medi-Cal Dental Program) covers some dental services.
  - If you have questions or want to learn more about dental services, call the Medi-Cal Dental Program at 1-800-322-6384 (TTY 1-800-735-2922 or 711), 8:00 a.m. to 5:00 p.m., Monday through Friday. You may also visit the Medi-Cal Dental Program website at <https://www.dental.dhcs.ca.gov> or <https://smilecalifornia.org/>.
- **Behavioral Health Services**
  - Non-specialty mental health services (NSMHS) are covered by CalOptima Health and specialty mental health services (SMHS) are covered by the Orange County Health Care Agency's (OCHCA) Mental Health Plan.
  - If you have questions or want to learn more about behavioral health services, call the CalOptima Health Behavioral Health Line at **1-855-877-3885 (TTY 711)**, 24 hours a day, 7 days a week.
- **In Home Supportive Services (IHSS)**
  - If you have questions or want to learn more about In Home Supportive Services (IHSS), call the Orange County Social Service Agency at 1-714-825-3000 or 1-800-281-9799 (TTY 1-800-735-2929).

### **J2. Provider and Pharmacy Directory**

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

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Customer Service at the numbers at the bottom of the page. Requests for hard copy *Provider and Pharmacy Directories* will be mailed to you within three business days.

You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 1: Getting started as a member

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The *Provider and Pharmacy Directory* gives you a listing of all health networks, PCPs, specialists, clinic, hospitals, and pharmacies contracted with CalOptima Health OneCare Flex Plus.

### Definition of network providers

- Our network providers include:
  - doctors, nurses, and other health care professionals that you can use as a member of our plan;
  - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**,
  - LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medi-Cal.

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

### Definition of network pharmacies

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

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

### J3. List of Covered Drugs

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

#### **J4. The *Explanation of Benefits***

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

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#### **K. Keeping your membership record up to date**

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

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you.

**They use your membership record to know what services and drugs you get and how much they cost you.**

Tell us right away about the following:

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

If any information changes, call Customer Service at the numbers at the bottom of the page.

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

**K1. Privacy of personal health information (PHI)**

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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

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### **Introduction**

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

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 2: Important phone numbers and resources

### A. Customer Service

<b>CALL</b>	<b>1-877-412-2734.</b> This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
<b>TTY</b>	<b>711.</b> This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.
<b>FAX</b>	<b>1-714-246-8711</b>
<b>WRITE</b>	CalOptima Health OneCare Flex Plus Customer Service 505 City Parkway West Orange, CA 92868
<b>EMAIL</b>	OneCarecustomerservice@caloptima.org
<b>WEBSITE</b>	<b><a href="http://www.caloptima.org/OneCare">www.caloptima.org/OneCare</a></b>

Contact Customer Service to get help with:

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
  - To learn more about making an appeal, refer to **Chapter 9** of your *Member Handbook* or contact Customer Service.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**, page 32).
  - You can call us and explain your complaint at **1-877-412-2734**.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above on page 25).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - You can make a complaint about our plan to the Medicare Medi-Cal Ombuds Program by calling 1-855-501-3077.
  - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Member Handbook*.
- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs **or**
    - the amount we pay for your drugs
  - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website ([www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov)) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.
  - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 2: Important phone numbers and resources

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- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above on page 26.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Member Handbook*.
- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Member Handbook*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Member Handbook*.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 2: Important phone numbers and resources

### B. Your Personal Care Coordinator

A CalOptima Health OneCare Flex Plus personal care coordinator is one main person for you to contact. This person helps manage all your providers and services and makes sure you get what you need.

<b>CALL</b>	<b>1-877-412-2734.</b> This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
<b>TTY</b>	<b>711.</b> This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.
<b>FAX</b>	<b>1-714-246-8711</b>
<b>WRITE</b>	CalOptima Health OneCare Flex Plus Customer Service 505 City Parkway West Orange, CA 92868
<b>EMAIL</b>	OneCarecustomerservice@caloptima.org
<b>WEBSITE</b>	<b><a href="http://www.caloptima.org/OneCare">www.caloptima.org/OneCare</a></b>

Contact your personal care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about dental benefits
- questions about transportation to medical appointments
- questions about Long-term Services and Supports (LTSS), including Community-Based Adult Services (CBAS) and Nursing Facilities (NF)
- questions about Community Supports



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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You might be able to get these services:

- Community-Based Adult Services (CBAS)
- skilled nursing care
- physical therapy
- occupational therapy
- speech therapy
- medical social services
- home health care
- In-Home Supportive Services (IHSS) through your county social service agency
- sometimes you can get help with your daily health care and living needs
- Community Supports
- Multipurpose Senior Services Program



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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### C. Health Insurance Counseling and Advocacy Program (HICAP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP has trained counselors in every county, and services are free.

HICAP is not connected with any insurance company or health plan.

<b>CALL</b>	1-800-434-0222 or 1-714-560-0424 Monday through Friday, 8 a.m. to 4 p.m.
<b>TTY</b>	1-800-735-2929 or 711. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WRITE</b>	The Council on Aging Southern California 2 Executive Circle, Suite 175 Irvine, CA 92614
<b>EMAIL</b>	help@coasc.org
<b>WEBSITE</b>	<a href="https://www.coasc.org/programs/hicap/">https://www.coasc.org/programs/hicap/</a>

Contact HICAP for help with:

- questions about Medicare
- HICAP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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### D. Nurse Advice Call Line

The Nurse Advice Call Line gives you access to a Registered Nurse (RN) to assist you with any questions about your health concerns. You can contact the Nurse Advice Call Line with questions about your health or health care.

<b>CALL</b>	<b>1-844-447-8441.</b> This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
<b>TTY</b>	<b>1-844-514-3774.</b> This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### E. Behavioral Health Crisis Line

If you are experiencing a life-threatening emergency, please dial **911**.

If you are experiencing a behavioral health crisis, call per below:

<b>CALL</b>	OC Links 1-855-625-4657. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
<b>TTY</b>	711. This call is not free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.

Contact the Behavioral Health Crisis Line for help with:

- questions about behavioral health and substance abuse services
- If you believe you are not in crisis and have general questions about behavioral health and substance abuse services, call the CalOptima Health Behavioral Health Line at **1-855-877-3885** (TTY **711**), 24 hours a day, 7 days a week.

For questions about your county specialty mental health services, refer to **Section K**, page 37.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### F. Quality Improvement Organization (QIO)

Our state has an organization called Livanta, LLC. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta, LLC is not connected with our plan.

<b>CALL</b>	1-877-588-1123
<b>TTY</b>	711 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WRITE</b>	Livanta, LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
<b>EMAIL</b>	Communications@Livanta.com
<b>WEBSITE</b>	<a href="https://www.livantaqio.cms.gov/en">https://www.livantaqio.cms.gov/en</a>

Contact Livanta, LLC. for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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### G. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### H. Medi-Cal

Medi-Cal is California's Medicaid program. This is a public health insurance program which provides needed health care services for low-income individuals, including families with children, seniors, persons with disabilities, children and youth in foster care, and pregnant women. Medi-Cal is financed by state and federal government funds.

Medi-Cal benefits include medical, dental, behavioral health, and long-term services and supports.

You are enrolled in Medicare and in Medi-Cal. If you have questions about your Medi-Cal benefits, call your plan personal care coordinator. If you have questions about Medi-Cal plan enrollment, call CalOptima Health Customer Service.

<b>CALL</b>	<b>1-888-587-8088</b> Monday through Friday, 8 a.m. to 5:30 p.m.
<b>TTY</b>	<b>711</b> This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
<b>WRITE</b>	CalOptima Health 505 City Parkway West Orange, CA 92868
<b>WEBSITE</b>	<b><a href="http://www.caloptima.org">www.caloptima.org</a></b>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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### I. Medi-Cal Managed Care and Mental Health Office of the Ombudsman

The Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Ombudsman also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### J. County Social Services

If you need help with your In-Home Supportive Services (IHSS) benefits, contact your local County Social Services agency. IHSS includes a wide range of services to meet your individual needs and help you live safely at home. In order to receive IHSS benefit, you must meet the program's eligibility requirements to qualify for IHSS. The following are some of the IHSS services may be available to you:

- Household and heavy cleaning, meal preparation, laundry, reasonable shopping and errands.
- Personal care services, such as feeding, bathing, bowel and bladder care, dressing, and other services.
- Assistance with transportation for medical appointments and health related services.
- Paramedical Care Services

Contact your county social services agency to apply for In Home Supportive Services, which will help pay for services provided to you so that you can remain safely in your own home. Types of services may include help with preparing meals, bathing, dressing, laundry shopping or transportation.

Contact your county social services agency for any questions about your Medi-Cal eligibility.

<b>CALL</b>	1-714-825-3000. This call is free. Monday through Friday, 8 a.m. to 5 p.m.
<b>TTY</b>	1-800-735-2929. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
<b>WRITE</b>	Orange County Social Services Agency 1505 East Warner Avenue Santa Ana, CA 92705
<b>WEBSITE</b>	<a href="https://ssa.ocgov.com/elderdisabled-home-services/home-supportive-services">https://ssa.ocgov.com/elderdisabled-home-services/home-supportive-services</a>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### K. County Behavioral Health Services Agency

Medi-Cal specialty mental health services and substance use disorder services are available to you through the county if you meet access criteria.

<b>CALL</b>	1-800-723-8641. This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
<b>TTY</b>	711. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Contact the county Behavioral Health agency for help with:

- questions about specialty mental health services provided by the county
- questions about substance use disorder services provided by the county
- Services include:
  - Specialty Mental Health Outpatient services
  - Medication support services
  - Crisis Intervention and Stabilization
  - Intensive Day treatment
  - Day rehabilitation
  - Adult and/or Crisis Residential treatment services
  - Targeted case management services
  - Outpatient Substance abuse services to include intensive Outpatient
  - Treatment services
  - Perinatal Residential services
  - Outpatient Drug Free services/Counseling
  - Narcotic treatment services and Naltrexone



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### L. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website ([www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs](http://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs)) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

#### L1. Extra Help

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

<b>CALL</b>	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
<b>TTY</b>	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<a href="http://www.medicare.gov">www.medicare.gov</a>

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

- To request assistance with obtaining evidence, or to provide us this evidence, please call CalOptima Health OneCare Flex Plus Customer Service at **1-877-412-2734 (TTY 711)**.
- When we receive the evidence showing your copayment level, we will update our system so that you will be charged the correct copayment when you get your next prescription. If you overpay your copayment, we will pay you back. Either we will send a check to you or we will deduct the amount from future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owned by you, we may make the payment directly to the pharmacy. If the state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### L2. The Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a new payment option that works with your current drug coverage, and it may help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January- December). This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. "Extra Help" from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in this payment option, regardless of income level, and plans with drug coverage must offer this payment option. Contact us at the phone number at the bottom of the page or visit [Medicare.gov](https://www.Medicare.gov) to find out if this payment option is right for you.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](https://www.caloptima.org/OneCare).

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### M. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S. Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

<b>CALL</b>	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">www.ssa.gov</a>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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### N. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive Medicare through the RRB, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the RRB, contact the agency.

<b>CALL</b>	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are <i>not</i> free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">www.rrb.gov</a>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## O. Other resources

The Medicare Medi-Cal Ombuds Program offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.

If you have problems with:

- Medi-Cal
- Medicare
- your health plan
- accessing medical services
- appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- medical billing
- IHSS (In-Home Supportive Services)

The Medicare Medi-Cal Ombuds Program assists with complaints, appeals, and hearings. The phone number for the Ombuds Program is 1-855-501-3077.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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### P. Medi-Cal Dental Program

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

- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

Dental benefits are available through Medi-Cal Dental Fee-for-Service (FFS).

<b>CALL</b>	1-800-322-6384 The call is free. Medi-Cal Dental FFS Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday.
<b>TTY</b>	1-800-735-2922 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<a href="http://www.dental.dhcs.ca.gov">www.dental.dhcs.ca.gov</a> <a href="http://smilecalifornia.org">smilecalifornia.org</a>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

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### **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 personal 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*.

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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## 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. 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 most Medi-Cal services. This includes certain behavioral health and LTSS.

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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- Our plan's PCPs are affiliated with health networks. When you choose your PCP, you are also choosing the affiliated health network. This means that your PCP refers you to specialists and services that are also affiliated with their health network. A health network is a group of doctors and hospitals that contracts with CalOptima Health OneCare Flex Plus to provide covered services to our members.
- 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 that are affiliated with your PCP's health network.** Usually, we won't cover care from a provider who doesn't work with our health plan and your PCP's health network. 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. This requires a prior authorization. In this situation, we cover the care at no cost to you.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.
  - 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 personal care coordinator will contact you to help you find providers in our network that are affiliated with your PCP's health network. After 12 months, we will no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's health network.



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**New members to CalOptima Health OneCare Flex Plus:** In most instances, you will be enrolled in CalOptima Health OneCare Flex Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in CalOptima Health OneCare Flex Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through CalOptima Health OneCare Flex Plus. There will be no gap in your Medi-Cal coverage. Please call us at **1-877-412-2734 (TTY 711)** if you have any questions.

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## C. Your personal care coordinator

### C1. What a personal care coordinator is

A personal care coordinator is a clinician or other trained person who works for our plan to provide care coordination services for you.

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

You can find your personal care coordinator phone number on the front of your CalOptima Health OneCare Flex Plus ID card.

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

You can call CalOptima Health OneCare Flex Plus and request the change at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week.

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## D. Care from providers

### D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care. Our plan's PCPs are affiliated with health networks. When you choose your PCP, you are also choosing the affiliated health network.

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

What is a PCP? Your PCP is a physician who meets state requirements and is trained to give you basic medical care.

What is a health network? Your health network is a group of doctors and hospitals contracted to provide health care services to members in our plan.



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What types of providers may act as a PCP? The CalOptima Health OneCare Flex Plus *Provider and Pharmacy Directory* lists all the network providers who may act as a PCP. Certain specialists including obstetricians-gynecologists may act as a PCP if they agree to do so and are listed as a PCP in the *Provider and Pharmacy Directory*.

You will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of CalOptima Health OneCare Flex Plus. Coordinating your services means checking or consulting with other plan providers about your care and how it is going. In most cases you must see your PCP to get a referral before you see any other health care provider or for prior approval of certain covered services or supplies. For certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist).

Can a clinic be my primary care provider? Yes. Members may choose Federally-Qualified Health Centers (FQHC) listed as PCPs in the CalOptima Health OneCare Flex Plus *Provider and Pharmacy Directory* as their primary care provider.

### Your choice of PCP

CalOptima Health OneCare Flex Plus has a *Provider and Pharmacy Directory* available upon request. This directory gives you a listing of all health networks, PCPs, specialists, clinics and hospitals contracted with CalOptima Health OneCare Flex Plus to provide services to CalOptima Health OneCare Flex Plus members. To request a *Provider and Pharmacy Directory* please call CalOptima Health OneCare Flex Plus Customer Service at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week.

The PCPs are listed by city under their affiliated health networks. Find the name of the PCP that you want as your primary care provider. Your PCP must be with the health network that you choose.

Look below the PCP's name to find his/her ID number and call CalOptima Health OneCare Flex Plus Customer Service to let us know your choice.

If there is a particular specialist or hospital that you want to use, find out if they're affiliated with your PCP's health network. You can look in the *Provider and Pharmacy Directory* or ask Customer Service to find out if the PCP you want makes referrals to that specialist or uses that hospital.



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### Option to change your PCP

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

You can change your PCP at any time by calling Customer Service at the phone number at the bottom of the page or by accessing our secure online member portal at <https://member.caloptima.org/#/user/login>. In most cases, the effective date of your new PCP will be the first (1st) of the month following the date your request is received.

If you need help choosing a PCP, call CalOptima Health OneCare Flex Plus Customer Service. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). We will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. We will also check to be sure the PCP you want to switch to is accepting new patients. Customer Service will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect. We will also send you a new ID card that shows the name and phone number of your new PCP.

Our plan's PCPs are affiliated with health networks. If you change your PCP, you may also be changing health networks. When you ask for a change, tell Customer Service if you use a specialist or get other covered services that must have PCP approval. Customer Service helps you continue your specialty care and other services when you change your PCP.

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

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

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

**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. If you call Customer Service before you leave the service area, we can help you receive dialysis while you're away.



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- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if you are an American Indian Member, you may obtain Covered Services from an Indian Health Care Provider of your choice, without requiring a referral from a Network PCP or Prior Authorization.

### **D2. Care from specialists and other network providers**

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

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

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from CalOptima Health OneCare Flex Plus (this is called getting "prior authorization"). Please refer to the Benefits Chart in **Chapter 4** for information about which services require prior authorization.

A written referral may be for a single 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 Customer Service at the number at the bottom of this page.



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#### D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We 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. Authorization rules may apply. Talk to your provider and get a referral.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Call Customer Service at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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### D4. Out-of-network providers

CalOptima Health OneCare Flex Plus members must go to contracted providers and pharmacies within Orange County in order to receive benefits. CalOptima Health OneCare Flex Plus will cover out-of-network providers in the following situations:

- Emergency care and out-of-area urgent services that you get from an out-of-network provider within the United States and its territories.
- If you need medical care that CalOptima Health OneCare Flex Plus covers and the providers in the CalOptima Health OneCare Flex Plus network cannot provide this care, you can get this care from an out-of-network provider with prior authorization.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside of our service area, which is Orange County.
- Family planning.
- Native American Indian Health Care Services.
- Women's obstetrical and some gynecological services like a pap smear.
- 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.
- During a declared disaster or public health emergency, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you.



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When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from CalOptima Health OneCare Flex Plus (this is called getting “prior authorization”).

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.

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## 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.

If you have questions or need assistance, please call your personal care coordinator at the phone number in the front of your ID card.



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## 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 the OCHCA Mental Health Plan Access Line at 1-800-723-2641, 24 hours a day, 7 days per week.

### 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 the OCHCA Mental Health Plan 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
- peer support services
- community-based mobile crisis intervention services
- intensive care coordination
- intensive home-based services

Drug Medi-Cal Organized Delivery System services are available to you through the OCHCA Mental Health Plan if you meet criteria to receive these services. Drug Medi-Cal services provided by the OCHCA Mental Health Plan include:

- intensive outpatient treatment services



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- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program
- medications for addiction treatment (also called Medication Assisted Treatment)
- peer support services
- community-based mobile crisis intervention services

Drug Medi-Cal Organized Delivery System Services include:

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- peer support services
- community-based mobile crisis intervention services
- contingency management services

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

Specialty Mental Health Services that are not covered by CalOptima Health OneCare Flex Plus will be coordinated for care with OCHCA Mental Health Plan through the Health Care Agency to ensure seamless access to enrollees. Enrollees should first contact the CalOptima Health Behavioral Health Line at **1-855-877-3885 (TTY 711)** for an assessment and referral to the appropriate level of services.

For additional information regarding the availability of behavioral health services, processes to determine medical necessity, referral procedures between the plan and county entity, and problem resolution processes, please contact CalOptima Health Behavioral Health Line at **1-855-877-3885 (TTY 711)**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## 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. If you need non-emergency medical transportation, you can talk to your PCP and ask for it. Your PCP 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 CalOptima Health OneCare Flex Plus for approval. Depending on your medical need, the approval is good for one year. Your PCP 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. CalOptima Health OneCare Flex Plus allows the lowest cost covered transportation mode and most appropriate non-emergency medical transportation for your medical needs when you need a ride to your appointment. For example, if you can physically or medically be transported by a wheelchair van, CalOptima Health OneCare Flex Plus will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

- You physically or medically need it as determined by written authorization from your PCP because you are not able to use a bus, taxi, car, or van to get to your appointment.
- You need help from the driver to and from your residence, vehicle, or place of treatment due to a physical or mental disability.

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call CalOptima Health OneCare Flex Plus at **1-866-612-1256 (TTY 711)** at least two (2) business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### Medical transportation limits

CalOptima Health OneCare Flex Plus covers the lowest cost medical transportation that meets your medical needs from your home to the closest provider where an appointment is available. Medical transportation will not be provided if Medicare or Medi-Cal does not cover the service. If the appointment type is covered by Medi-Cal but not through the health plan, CalOptima Health OneCare Flex Plus will help you schedule your transportation. A list of covered services is in **Chapter 4** of this handbook. Transportation is not covered outside CalOptima Health OneCare Flex Plus 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 are:

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

CalOptima Health OneCare Flex Plus allows you to use a car, taxi, bus, or other public/private way of getting to your non-medical appointment for services authorized by your provider. CalOptima Health OneCare Flex Plus uses a transportation 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. CalOptima Health OneCare Flex Plus must approve this **before** you get the ride, and you must tell us why you can't get a ride in another way, like taking the bus. You can tell us by calling or emailing, or in person. **You cannot be reimbursed for driving yourself.**

Mileage reimbursement requires all of the following:

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

To ask for a ride for services that have been authorized, call CalOptima Health OneCare Flex Plus at **1-866-612-1256 (TTY 711)** at least two (2) business days (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.



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

### **Non-medical transportation limits**

CalOptima Health OneCare Flex Plus provides the lowest cost non-medical transportation that meets your needs from your home to the closest provider where an appointment is available. **You cannot drive yourself or be reimbursed directly.**

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

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



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## 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 or worldwide, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. Call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week for more information.

### Covered services in a medical emergency

Medicare does not provide coverage for emergency medical care outside the United States and its territories.

CalOptima Health OneCare Flex Plus provides an extra benefit by reimbursing up to \$100,000 per year for emergency medical care received outside the United States.



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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.

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 an unforeseen illness or injury.

#### **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, given your time, place or circumstances, we cover urgently needed care you get from an out-of-network provider.

Contact your health network to find out how to access urgent care services. Your health network phone number can be found on your CalOptima Health OneCare Flex Plus membership ID card.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### 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.

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

Our plan covers worldwide emergency and urgently needed care services outside the United States under the following circumstances.

- We provide a \$100,000 benefit per calendar year for emergency, urgent care services and emergency transportation received outside the United States. Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States.
- You must first pay for medical care received, obtain a discharge summary or equivalent medical documentation and proof of payment, preferably in English and U.S. dollars. Submit the reimbursement request with all supporting documentation to CalOptima Health OneCare Flex Plus and we will review for medical necessity and appropriateness before reimbursement is made.

### 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: <https://www.caloptima.org/ForMembers/OneCare/Benefits>.

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



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

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

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

If you paid for your covered services or if you got a bill for 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

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 Customer Service 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 Customer Service to find out what the benefit limits are and how much of your benefits you've used.



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

### J1. Definition of a clinical research study

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

Once Medicare approves a study you want to be in, 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 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 requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies 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 personal care coordinator to contact Customer Service to let us know you will take part in a clinical trial.

### J2. Payment for services when you participate 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



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If you're part of a study that Medicare 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](http://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.

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## 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

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.



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

Medicare Inpatient Hospital coverage limits apply. Please refer to the Benefits Chart in **Chapter 4**.

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## L. Durable medical equipment (DME)

### L1. DME as a member of our plan

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you usually will **not** own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Customer Service 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.



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**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* 2025 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](http://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.



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## 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.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## Chapter 4: Benefits Chart

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### Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

**New members to CalOptima Health OneCare Flex Plus:** In most instances you will be enrolled in CalOptima Health OneCare Flex Plus for your Medicare benefits the 1st day of the month after you request to be enrolled in CalOptima Health OneCare Flex Plus. You may still receive your Medi-Cal services from your previous Medi-Cal health plan for one additional month. After that, you will receive your Medi-Cal services through CalOptima Health OneCare Flex Plus. There will be no gap in your Medi-Cal coverage. Please call us at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week if you have any questions.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## **A. Your covered services**

This chapter tells you about services our plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Member Handbook*. This chapter also explains limits on some services.

If you need help understanding what services are covered, call Customer Service at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week.

If you lose your Medi-Cal eligibility, CalOptima Health OneCare Flex Plus will continue to cover all of your Medicare covered benefits for up to 6-months while you re-apply for Medi-Cal (6-month period of deemed continued eligibility). However, during this period, we will not continue to cover Medi-Cal (Medicaid) benefits that are included under the applicable Medi-Cal (Medicaid) State Plan, and we will not pay the Medicare premiums or cost-sharing that Medi-Cal would pay on your behalf. Medicare cost-sharing amounts for Medicare basic and supplemental benefits do not change during this period. However, you may be responsible for Medicare cost-sharing (co-insurance) of 20% if you go to an out-of-network, non-contracted provider.

### **A1. During public health emergencies**

During a public health emergency (PHE), CalOptima Health OneCare Flex Plus will consider adoption of certain flexibilities granted by regulatory agencies, including the Centers for Medicare & Medicaid Services (CMS) and/or the California state Department of Health Care Services (DHCS). For example, during the COVID-19 pandemic, CalOptima Health OneCare Flex Plus continued to extend all pre-existing authorizations received to ensure members have timely access to the services. CalOptima Health OneCare Flex Plus also implemented telephonic and/or video in place of face-to-face interactions according to members needs and preference throughout the duration of the public health emergency, including any future public health emergency extension(s).

Any flexibility is contingent upon the duration of the public health emergency, which may or may not last for the entire year.

For any questions, you can contact CalOptima Health OneCare Flex Plus Customer Service at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Member Handbook* or call Customer Service.

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## C. About our plan's Benefits Chart

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

**We pay for the services listed in the Benefits Chart when the following rules are met.** You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For new enrollees, the plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Member Handbook* has more information about using network and out-of-network providers.



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- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan's network. This is called a referral. **Chapter 3** of your *Member Handbook* has more information about getting a referral and when you do **not** need one.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with an asterisk (\*).
- If your plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- If you lose your Medi-Cal benefits, within the six (6) months period of deemed continued eligibility, your Medicare benefits in this plan will continue. However, your Medi-Cal service may not be covered. Contact your county eligibility office or Health Care Options for information about your Medi-Cal eligibility. You can keep your Medicare benefits, but not your Medi-Cal benefits.


**Important Benefit Information for Members with Certain Chronic Conditions.**

- If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
- Chronic alcohol and other drug dependence;
- Autoimmune disorders limited to Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus;
- Cancer, excluding pre-cancer conditions or in-situ status;
- Cardiovascular disorders limited to Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and Chronic venous thromboembolic disorder;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
- End-stage liver disease; End-stage renal disease (ESRD) requiring dialysis;
- Severe hematologic disorders limited to Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplastic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder;
- HIV/AIDS;



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- Chronic lung disorders limited to Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, and Pulmonary hypertension;
- Chronic and disabling mental health conditions limited to Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, and Schizoaffective disorder; Neurologic disorders limited to Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington’s disease, Multiple sclerosis, Parkinson’s disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit; and
- Stroke.
- Not all members will be eligible for additional benefits. Members must:
  - Have one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee
  - Have a high risk of hospitalization or other adverse health outcomes; and
  - Require intensive care coordination.
- To determine if you are eligible for additional benefits, your provider will confirm your diagnosis or CalOptima Health OneCare Flex Plus will complete a health risk assessment (HRA).
- Please see the “Help with certain chronic conditions” row in the Benefits Chart for more information.
- Please contact us to find out if you are eligible for additional benefits.

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





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**D. Our plan's Benefits Chart**

Services that our plan pays for	What you must pay
 <p><b>Abdominal aortic aneurysm screening</b></p> <p>We pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>\$0</p>
<p><b>Acupuncture</b></p> <p>We pay for up to two outpatient acupuncture services in any one calendar month, or more often if they are medically necessary.</p> <p>We also pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as:</p> <ul style="list-style-type: none"> <li>• lasting 12 weeks or longer;</li> <li>• not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease);</li> <li>• not associated with surgery; <b>and</b></li> <li>• not associated with pregnancy.</li> </ul> <p>In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments must be stopped if you don't get better or if you get worse.</p>	<p>\$0</p>






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Services that our plan pays for	What you must pay
 <p><b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol and drug misuse screening, also known as Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) per year for adults who misuse alcohol and/or drugs but are not alcohol and/or drug dependent. This includes pregnant women.</p> <p>Additional screenings may be provided when medically necessary. Medical necessity must be documented by your primary care provider (PCP) or practitioner in a primary care setting.</p>	<p>\$0</p>
<p><b>Ambulance services*</b></p> <p>Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter). The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life.</p> <p>Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p> <p>*Authorization rules may apply.</p>	<p>\$0</p>
 <p><b>Annual physical exam</b></p> <p>We encourage you to get one routine physical exam per year. This exam will be a full assessment of your health and will include laboratory and other screening services, as needed. The exam is covered if it is medically appropriate preventive care.</p>	<p>\$0</p>





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Services that our plan pays for	What you must pay
 <p><b>Annual wellness visit</b></p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.</p> <p><b>Note:</b> Your first annual wellness visit can't take place within 12 months of your <b>Welcome to Medicare</b> visit. However, you don't need to have had a <b>Welcome to Medicare</b> visit to get annual wellness visits after you've had Part B for 12 months.</p>	\$0
<p><b>Asthma Preventive Services</b></p> <p>You can receive asthma education and a home environment assessment for triggers commonly found in the home for people with poorly controlled asthma.</p>	\$0
 <p><b>Bone mass measurement</b></p> <p>We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality.</p> <p>We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.</p>	\$0
 <p><b>Breast cancer screening (mammograms)</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>● one baseline mammogram between the ages of 35 and 39</li> <li>● one screening mammogram every 12 months for women age 40 and over</li> <li>● clinical breast exams once every 24 months</li> </ul>	\$0




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Services that our plan pays for	What you must pay
<p><b>Cardiac (heart) rehabilitation services*</b></p> <p>We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor’s referral.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	\$0
<p> <b>Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</b></p> <p>We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visits, your doctor may:</p> <ul style="list-style-type: none"> <li>• discuss aspirin use,</li> <li>• check your blood pressure, <b>and/or</b></li> <li>• give you tips to make sure you are eating well.</li> </ul>	\$0
<p> <b>Cardiovascular (heart) disease testing</b></p> <p>We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.</p>	\$0




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Services that our plan pays for	What you must pay
 <p><b>Cervical and vaginal cancer screening</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• for all women: Pap tests and pelvic exams once every 24 months</li> <li>• for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months</li> <li>• for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months</li> <li>• for women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years</li> </ul>	<p>\$0</p>
<p><b>Chiropractic services</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• adjustments of the spine to correct alignment</li> </ul> <p>Medi-Cal covers chiropractic services limited to two services per month in combination with acupuncture, audiology, occupational therapy and speech therapy services. Medi-Cal may pre-approve other services as medically necessary.</p> <p>The following members are eligible for chiropractic services:</p> <ul style="list-style-type: none"> <li>• Pregnant people through the end of the month that includes 60-days following the end of a pregnancy</li> <li>• Residents in a skilled nursing facility, intermediate care facility, or subacute care facility</li> <li>• All members when services are provided at county hospital outpatient departments, outpatient clinics, FQHCs or RHCs that are in the CalOptima Health’s network. Not all FQHCs, RHCs or county hospitals offer outpatient chiropractic services.</li> </ul>	<p>\$0</p>




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Services that our plan pays for	What you must pay
 <p><b>Colorectal cancer screening*</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema.</li> <li>• Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema.</li> <li>• Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.</li> <li>• Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.</li> <li>• Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy.</li> <li>• Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
 <p><b>Colorectal cancer screening* (continued)</b> Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. *Talk to your provider and get a referral.</p>	<p>\$0</p>
<p><b>Community-Based Adult Services (CBAS)*</b> CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We pay for CBAS if you meet the eligibility criteria. <b>Note:</b> If a CBAS facility is not available, we can provide these services separately. *Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Dental services*</b></p> <p>We pay for certain dental services, including but not limited to, cleanings, fillings, and dentures. What we do not cover is available through Medi-Cal Dental, described in <b>Section F2</b> below.</p> <p>We pay for some dental services when the service is an integral part of specific treatment of a beneficiary’s primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.</p> <p>We provide coverage for comprehensive dental services including:</p> <ul style="list-style-type: none"> <li>● Limited oral evaluation,</li> <li>● Diagnostic x-rays,</li> <li>● periodontic services,</li> <li>● endodontic services,</li> <li>● prosthodontics,</li> <li>● oral and maxillofacial surgery, and</li> <li>● other general dental services.</li> </ul> <p>What we do not cover is available through Medi-Cal Dental.</p> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>
<p> <b>Depression screening</b></p> <p>We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
 <p><b>Diabetes screening</b></p> <p>We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> <li>• high blood pressure (hypertension)</li> <li>• history of abnormal cholesterol and triglyceride levels (dyslipidemia)</li> <li>• obesity</li> <li>• history of high blood sugar (glucose)</li> </ul> <p>Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes.</p> <p>You may qualify for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p><b>Diabetic self-management training, services, and supplies*</b></p> <p>We pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> <li>● Supplies to monitor your blood glucose, including the following:                             <ul style="list-style-type: none"> <li>○ a blood glucose monitor</li> <li>○ blood glucose test strips</li> <li>○ lancet devices and lancets</li> <li>○ glucose-control solutions for checking the accuracy of test strips and monitors</li> </ul> </li> <li>● For people with diabetes who have severe diabetic foot disease, we pay for the following:                             <ul style="list-style-type: none"> <li>○ one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, <b>or</b></li> <li>○ one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)</li> </ul> </li> <li>● In some cases, we pay for training to help you manage your diabetes. To find out more, contact Customer Service.</li> </ul> <p>*Authorization rules may apply</p>	<p>\$0</p>
<p><b>Doula Services</b></p> <p>For individuals who are pregnant we pay for nine visits with a doula during the prenatal and postpartum period as well as support during labor and delivery.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Durable medical equipment (DME) and related supplies*</b></p> <p>Refer to <b>Chapter 12</b> of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <li>● wheelchairs, including electric wheelchairs</li> <li>● crutches</li> <li>● powered mattress systems</li> <li>● dry pressure pad for mattress</li> <li>● diabetic supplies</li> <li>● hospital beds ordered by a provider for use in the home</li> <li>● intravenous (IV) infusion pumps and pole</li> <li>● speech generating devices</li> <li>● oxygen equipment and supplies</li> <li>● nebulizers</li> <li>● walkers</li> <li>● standard curved handle or quad cane and replacement supplies</li> <li>● cervical traction (over the door)</li> <li>● bone stimulator</li> <li>● dialysis care equipment</li> </ul> <p>Other items may be covered.</p> <p>We pay for all medically necessary DME that Medicare and Medi-Cal usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special order it for you.</p> <p>*Authorization rules may apply.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Emergency care</b></p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> <li>● given by a provider trained to give emergency services, <b>and</b></li> <li>● needed to treat a medical emergency.</li> </ul> <p>A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:</p> <ul style="list-style-type: none"> <li>● serious risk to your health or to that of your unborn child; <b>or</b></li> <li>● serious harm to bodily functions; <b>or</b></li> <li>● serious dysfunction of any bodily organ or part.</li> <li>● In the case of a pregnant woman in active labor, when: <ul style="list-style-type: none"> <li>○ There is not enough time to safely transfer you to another hospital before delivery.</li> <li>○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.</li> </ul> </li> </ul> <p>We provide a \$100,000 benefit for emergency and urgent care and emergency transportation received outside the United States.</p> <p>Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States.</p> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital in order for your care to continue to be covered <b>OR</b> you must have your inpatient care at the out-of-network hospital authorized by the plan.</p> <p>You pay for your emergency and urgent care and emergency transportation outside of the U.S. and we will reimburse you up to \$100,000 per year.</p>



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Services that our plan pays for		What you must pay
	<p><b>Emergency care (continued)</b></p> <p>You must first pay for medical care received, obtain a discharge summary or equivalent medical documentation and proof of payment, preferably in English and U.S. dollars. Submit the reimbursement request with all supporting documentation to CalOptima Health OneCare Flex Plus and we will review for medical necessity and appropriateness before reimbursement is made.</p>	\$0
	<p><b>Enhanced Drug Benefit</b></p> <p>Erectile dysfunction drug treatment covers 4 tablets per month (generic).</p>	\$0



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Services that our plan pays for	What you must pay
<p><b>Family planning services</b></p> <p>The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office.</p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>● family planning exam and medical treatment</li> <li>● family planning lab and diagnostic tests</li> <li>● family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring)</li> <li>● family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)</li> <li>● limited fertility services such as counseling and education about fertility awareness techniques, and/or preconception health counseling, testing, and treatment for sexually transmitted infections (STIs)</li> <li>● counseling and testing for HIV and AIDS, and other HIV-related conditions</li> <li>● permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>● genetic counseling</li> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Family planning services (continued)</b></p> <p>We also pay for some other family planning services. However, you must use a provider in our provider network for the following services:</p> <ul style="list-style-type: none"><li>● treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)</li><li>● treatment for AIDS and other HIV-related conditions</li><li>● genetic testing</li></ul>	\$0




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Services that our plan pays for	What you must pay
<p><b>Flex Card: Over the Counter (OTC) and Grocery Items allowance</b></p> <p>\$245 total allowance or spending limit per quarter (every 3 months) to purchase:</p> <ul style="list-style-type: none"> <li>• OTC items and supplies available at retail stores and through an OTC mail-order catalog, and</li> <li>• Some members with certain chronic health conditions** may qualify to use the \$245 flex card per quarter to purchase groceries in addition to over-the-counter items.</li> </ul> <p>This benefit becomes valid on the first day of each quarter; January, April, July and October; any remaining balance does not carry over to the next quarter(s).</p> <p>You can use this benefit to buy non-prescription items such as cold and cough preparations, acetaminophen, bandages, and other eligible products. If ordered through the OTC mail order catalog, items will be shipped directly to your home.</p> <p>You will receive a mail-order catalog with ordering instructions and details about the items you can purchase with your allowance.</p> <p>You can use this benefit to buy eligible grocery items including but not limited to fresh produce, whole foods, and canned foods. Alcohol, tobacco, sugary drinks, and other items will not be available to buy with the flex card allowance.</p> <p>**Not all members will qualify to buy grocery items. Please see the “Help with certain chronic conditions” row later in this chart for information on how to qualify to buy grocery items.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
 <p><b>Health and wellness education programs</b></p> <p>We offer many programs that focus on certain health conditions. These include:</p> <ul style="list-style-type: none"> <li>● Health Education classes;</li> <li>● Nutrition Education classes;</li> <li>● Smoking and Tobacco Use Cessation; <b>and</b></li> <li>● Nursing Hotline</li> </ul> <p>You have the following options available at no cost to you:</p> <ul style="list-style-type: none"> <li>● Membership at participating fitness centers or YMCAs that take part in the program.</li> <li>● An exercise and healthy aging program designed specifically for Medicare beneficiaries including no cost membership options at available fitness facilities or exercise centers.</li> <li>● A variety of on-demand videos through the website.</li> <li>● Healthy Aging Coaching sessions by phone, video, or chat with a trained coach where you can discuss topics like exercise, nutrition, social isolation, and brain health.</li> <li>● Activity Tracker Tool.</li> <li>● You are eligible to receive one of the following home fitness kit per benefit year             <ul style="list-style-type: none"> <li>○ Wearable Fitness Tracker Kit,</li> <li>○ Beginner Yoga Kit with a mat and hand towel,</li> <li>○ Walking/Trekking Kit with 2 walking poles,</li> <li>○ Intermediate/Advanced Yoga Kit with a yoga strap and 2 yoga blocks,</li> </ul> </li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p><b>Health and wellness education programs (continued)</b></p> <ul style="list-style-type: none"> <li>○ Pilates Kit with a Pilates ball and towel,</li> <li>○ Beginner Strength Kit with 2-pound dumbbells and exercise bands,</li> <li>○ Beginner Swim Kit with swimming goggles and a kickboard,</li> <li>○ Intermediate Strength Kit with 3-pound dumbbells and exercise bands,</li> <li>○ Advanced Swim Kit with aquatic resistance gloves and a pull float, or</li> <li>○ Advanced Strength Kit with 5-pound dumbbells and exercise bands.</li> <li>● Online Healthy Aging classes.</li> <li>● Well-Being Club for exclusive articles and videos and live virtual classes and events</li> <li>● Customized Workout Plans</li> </ul>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Hearing services*</b></p> <p>We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.</p> <p>We also pay for hearing aids when prescribed by a physician or other qualified provider, including:</p> <ul style="list-style-type: none"> <li>• molds, supplies, and inserts</li> <li>• repairs</li> <li>• an initial set of batteries</li> <li>• six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid</li> <li>• trial period rental of hearing aids</li> <li>• assistive listening devices, surface-worn bone conduction hearing devices</li> <li>• hearing aid-related audiology and post-evaluation services</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p> <p>CalOptima Health OneCare Flex Plus covers up to \$1,000 allowance for hearing aids every calendar year, beyond the Medi-Cal limit of \$1,510.</p> <p>The \$1,000 amount may be used for one ear or two ears, but this benefit may only be used once during the calendar year.</p> <p>You are responsible for any amount beyond this limit.</p>




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Services that our plan pays for	What you must pay
<p><b>Help with certain chronic conditions</b></p> <p>Members who have certain chronic conditions, have a high risk of hospitalization, and require intensive care coordination may be eligible for extra benefits. The chronic conditions include Chronic alcohol and other drug dependence; Autoimmune disorders limited to Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Rheumatoid arthritis, and Systemic lupus erythematosus; Cancer, excluding pre-cancer conditions or in-situ status; Cardiovascular disorders limited to Cardiac arrhythmias, Coronary artery disease, Peripheral vascular disease, and Chronic venous thromboembolic disorder; Chronic heart failure; Dementia; Diabetes mellitus; End-stage liver disease; End-stage renal disease (ESRD) requiring dialysis; Severe hematologic disorders limited to Aplastic anemia, Hemophilia, Immune thrombocytopenic purpura, Myelodysplastic syndrome, Sickle-cell disease (excluding sickle-cell trait), and Chronic venous thromboembolic disorder; HIV/AIDS; Chronic lung disorders limited to Asthma, Chronic bronchitis, Emphysema, Pulmonary fibrosis, and Pulmonary hypertension; Chronic and disabling mental health conditions limited to Bipolar disorders, Major depressive disorders, Paranoid disorder, Schizophrenia, and Schizoaffective disorder; Neurologic disorders limited to Amyotrophic lateral sclerosis (ALS), Epilepsy, Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia), Huntington’s disease, Multiple sclerosis, Parkinson’s disease, Polyneuropathy, Spinal stenosis, and Stroke-related neurologic deficit; and Stroke.</p> <p><b>Grocery Items allowance</b></p> <p>Please see the “Flex Card: Over the Counter (OTC) and Grocery Items allowance” row earlier in this chart for information on what is included in this benefit.</p>	<p>\$0</p>



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



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Services that our plan pays for	What you must pay
<p><b>Home infusion therapy*</b></p> <p>Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion:</p> <ul style="list-style-type: none"> <li>● the drug or biological substance, such as an antiviral or immune globulin;</li> <li>● equipment, such as a pump; <b>and</b></li> <li>● supplies, such as tubing or a catheter.</li> </ul> <p>Our plan covers home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> <li>● professional services, including nursing services, provided in accordance with your care plan;</li> <li>● member training and education not already included in the DME benefit;</li> <li>● remote monitoring; <b>and</b></li> <li>● monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Hospice care</b></p> <p>You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan’s service area. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• drugs to treat symptoms and pain</li> <li>• short-term respite care</li> <li>• home care</li> </ul> <p><b>Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b> of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or Medicare Part B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services.</li> </ul> <p><b>For drugs that may be covered by our plan’s Medicare Part D benefit:</b></p> <ul style="list-style-type: none"> <li>• Drugs are never covered by both hospice and our plan at the same time. For more information, refer to <b>Chapter 5</b> of your <i>Member Handbook</i>.</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0 copayment for Medicare-covered hospice care.</p> <p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not CalOptima Health OneCare Flex Plus.</p>



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Services that our plan pays for	What you must pay
<p><b>Hospice care (continued)</b></p> <p><b>Note:</b> If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section below for more information.</p> <p><b>Note:</b> If you need non-hospice care, call your personal care coordinator and/or Customer Service to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.</p>	<p>\$0</p>
<p> <b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• pneumonia vaccines</li> <li>• flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary</li> <li>• hepatitis B vaccines if you are at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccines</li> <li>• human papillomavirus (HPV) vaccine</li> <li>• other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to <b>Chapter 6</b> of your <i>Member Handbook</i> to learn more.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient hospital care*</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>● semi-private room (or a private room if medically necessary)</li> <li>● meals, including special diets</li> <li>● regular nursing services</li> <li>● costs of special care units, such as intensive care or coronary care units</li> <li>● drugs and medications</li> <li>● lab tests</li> <li>● X-rays and other radiology services</li> <li>● needed surgical and medical supplies</li> <li>● appliances, such as wheelchairs</li> <li>● operating and recovery room services</li> <li>● physical, occupational, and speech therapy</li> <li>● inpatient substance abuse services</li> <li>● in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral.</li> </ul> <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community.</p> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p> <p>You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.</p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient hospital care* (continued)</b></p> <p>If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person.</p> <ul style="list-style-type: none"> <li>• blood, including storage and administration</li> <li>• physician services</li> </ul> <p><b>Note:</b> To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are you a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!”. This fact sheet is available at <a href="https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient services in a psychiatric hospital*</b></p> <p>We pay for mental health care services that require a hospital stay.</p> <ul style="list-style-type: none"> <li>● If you need inpatient services in a freestanding psychiatric hospital, we pay for the first 190 days. After that, the local county mental health agency pays for medically necessary inpatient psychiatric services. Authorization for care beyond the 190 days is coordinated with the local county mental health agency.                             <ul style="list-style-type: none"> <li>○ The 190-day limit does <b>not</b> apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</li> </ul> </li> <li>● If you are 65 years or older, we pay for services you get in an Institute for Mental Diseases (IMD).</li> </ul> <p>*Authorization rules may apply.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay*</b></p> <p>We do not pay for your inpatient stay if you have used all of your inpatient benefit or if the stay is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Customer Service.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>● doctor services</li> <li>● diagnostic tests, like lab tests</li> <li>● X-ray, radium, and isotope therapy, including technician materials and services</li> <li>● surgical dressings</li> <li>● splints, casts, and other devices used for fractures and dislocations</li> <li>● prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices.</li> </ul> <p>These are devices that replace all or part of:</p> <ul style="list-style-type: none"> <li>○ an internal body organ (including contiguous tissue), <b>or</b></li> <li>○ the function of an inoperative or malfunctioning internal body organ.</li> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay* (continued)</b></p> <ul style="list-style-type: none"> <li>• leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition</li> <li>• physical therapy, speech therapy, and occupational therapy</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>





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




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Services that our plan pays for	What you must pay
 <p><b>Lung cancer screening</b></p> <p>Our plan pays for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> <li>• are aged 50-77, <b>and</b></li> <li>• have a counseling and shared decision-making visit with your doctor or other qualified provider, <b>and</b></li> <li>• have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years.</li> </ul> <p>After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.</p>	<p>\$0</p>
 <p><b>Medical nutrition therapy*</b></p> <p>This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when referred by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor’s referral. A doctor must prescribe these services and renew the referral each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p> <p>* Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
 <p><b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> <li>• long-term dietary change, <b>and</b></li> <li>• increased physical activity, <b>and</b></li> <li>• ways to maintain weight loss and a healthy lifestyle.</li> </ul>	<p>\$0</p>
<p><b>Medicare Part B prescription drugs*</b></p> <p>These drugs are covered under Part B of Medicare. Our plan pays for the following drugs:</p> <ul style="list-style-type: none"> <li>• drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services</li> <li>• insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)</li> <li>• other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• the Alzheimer's drug, Leqembi (generic lecanemab) which is given intravenously (IV)</li> <li>• clotting factors you give yourself by injection if you have hemophilia</li> <li>• transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D covers immunosuppressive drugs if Part B does not cover them</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Medicare Part B prescription drugs* (continued)</b></p> <ul style="list-style-type: none"> <li>• osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself</li> <li>• some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision</li> <li>• certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does</li> <li>• oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug</li> <li>• certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it</li> <li>• calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv, and the oral medication Sensipar</li> <li>• certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary) and topical anesthetics</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Medicare Part B prescription drugs* (continued)</b></p> <ul style="list-style-type: none"> <li>• erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have ESRD or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Epoetin Alfa, or Aranesp®)</li> <li>• IV immune globulin for the home treatment of primary immune deficiency diseases</li> <li>• parenteral and enteral nutrition (IV and tube feeding)</li> </ul> <p>We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare Part D prescription drug benefit.</p> <p><b>Chapter 5</b> of your <i>Member Handbook</i> explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p><b>Chapter 6</b> of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> <p>*Authorization rules may apply.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Nursing facility care*</b></p> <p>A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital.</p> <p>Services that we pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> <li>● semiprivate room (or a private room if medically necessary)</li> <li>● meals, including special diets</li> <li>● nursing services</li> <li>● physical therapy, occupational therapy, and speech therapy</li> <li>● respiratory therapy</li> <li>● drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</li> <li>● blood, including storage and administration</li> <li>● medical and surgical supplies usually given by nursing facilities</li> <li>● lab tests usually given by nursing facilities</li> <li>● X-rays and other radiology services usually given by nursing facilities</li> <li>● use of appliances, such as wheelchairs usually given by nursing facilities</li> <li>● physician/practitioner services</li> <li>● durable medical equipment</li> <li>● dental services, including dentures</li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Nursing facility care* (continued)</b></p> <ul style="list-style-type: none"> <li>● vision benefits</li> <li>● hearing exams</li> <li>● chiropractic care</li> <li>● podiatry services</li> </ul> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment:</p> <ul style="list-style-type: none"> <li>● a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>● a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>
<p> <b>Obesity screening and therapy to keep weight down</b></p> <p>If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Opioid treatment program (OTP) services*</b></p> <p>Our plan pays for the following services to treat opioid use disorder (OUD):</p> <ul style="list-style-type: none"> <li>● intake activities</li> <li>● periodic assessments</li> <li>● medications approved by the FDA and, if applicable, managing and giving you these medications</li> <li>● substance use disorder counseling</li> <li>● individual and group therapy</li> <li>● testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p>*Authorization rules may apply.</p>	<p>\$0</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies*</b></p> <p>We pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> <li>● X-rays</li> <li>● radiation (radium and isotope) therapy, including technician materials and supplies</li> <li>● surgical supplies, such as dressings</li> <li>● splints, casts, and other devices used for fractures and dislocations</li> <li>● lab tests</li> <li>● blood, including storage and administration</li> <li>● other outpatient diagnostic tests</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient hospital services*</b></p> <p>We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:</p> <ul style="list-style-type: none"> <li>● Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services                             <ul style="list-style-type: none"> <li>○ Observation services help your doctor know if you need to be admitted to the hospital as “inpatient.”</li> <li>○ Sometimes you can be in the hospital overnight and still be “outpatient.”</li> <li>○ You can get more information about being inpatient or outpatient in this fact sheet: <a href="https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf">es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf</a>.</li> </ul> </li> <li>● Labs and diagnostic tests billed by the hospital</li> <li>● Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it</li> <li>● X-rays and other radiology services billed by the hospital</li> <li>● Medical supplies, such as splints and casts</li> <li>● Preventive screenings and services listed throughout the Benefits Chart</li> <li>● Some drugs that you can’t give yourself</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient mental health care*</b></p> <p>We pay for mental health services provided by:</p> <ul style="list-style-type: none"> <li>• a state-licensed psychiatrist or doctor</li> <li>• a clinical psychologist</li> <li>• a clinical social worker</li> <li>• a clinical nurse specialist</li> <li>• a licensed professional counselor (LPC)</li> <li>• a licensed marriage and family therapist (LMFT)</li> <li>• a nurse practitioner (NP)</li> <li>• a physician assistant (PA)</li> <li>• any other Medicare-qualified mental health care professional as allowed under applicable state laws</li> </ul> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• clinic services</li> <li>• day treatment</li> <li>• psychosocial rehab services</li> <li>• partial hospitalization or intensive outpatient programs</li> <li>• individual and group mental health evaluation and treatment</li> <li>• psychological testing when clinically indicated to evaluate a mental health outcome</li> <li>• outpatient services for the purposes of monitoring drug therapy</li> <li>• outpatient laboratory, drugs, supplies and supplements</li> <li>• psychiatric consultation</li> </ul> <p>*Authorization rules may apply.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Outpatient rehabilitation services*</b></p> <p>We pay for physical therapy, occupational therapy, and speech therapy.</p> <p>You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.</p> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>
<p><b>Outpatient substance use disorder services</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>● alcohol misuse screening and counseling</li> <li>● treatment of drug abuse</li> <li>● group or individual counseling by a qualified clinician</li> <li>● subacute detoxification in a residential addiction program</li> <li>● alcohol and/or drug services in an intensive outpatient treatment center</li> <li>● extended-release Naltrexone (vivitrol) treatment</li> </ul>	<p>\$0</p>
<p><b>Outpatient surgery*</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Palliative Care</b></p> <p>Palliative care is covered by our plan. Palliative care is for people with serious illness. It provides patient and family-centered care that improves quality of life by anticipating, preventing, and treating suffering. Palliative Care is not hospice, therefore you do <b>not</b> have to have a life expectancy of six months or less to qualify for palliative care. Palliative care is provided at the same time as curative/regular care.</p> <p>Palliative care includes the following:</p> <ul style="list-style-type: none"> <li>● advance care planning</li> <li>● palliative care assessment and consultation</li> <li>● a plan of care including all authorized palliative and curative care, including mental health and medical social services</li> <li>● services from your designated care team</li> <li>● care coordination</li> <li>● pain and symptom management</li> </ul> <p>You may not get hospice care and palliative care at the same time if you are over the age of 21. If you are getting palliative care and meet the eligibility for hospice care, you can ask to change to hospice care at any time.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Partial hospitalization services and intensive outpatient services*</b></p> <p>Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital.</p> <p>Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, LMFT, or licensed professional counselor's office but less intense than partial hospitalization.</p> <p>*Authorization rules may apply.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Physician/provider services, including doctor’s office visits*</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>● medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> <li>○ physician’s office</li> <li>○ certified ambulatory surgical center</li> <li>○ hospital outpatient department</li> </ul> </li> <li>● consultation, diagnosis, and treatment by a specialist</li> <li>● basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment</li> <li>● telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home</li> <li>● telehealth services to diagnose, evaluate, or treat symptoms of a stroke</li> <li>● telehealth services for members with a substance use disorder or co-occurring mental health disorder</li> <li>● telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: <ul style="list-style-type: none"> <li>○ you have an in-person visit within 6 months prior to your first telehealth visit</li> <li>○ you have an in-person visit every 12 months while receiving these telehealth services</li> <li>○ exceptions can be made to the above for certain circumstances</li> </ul> </li> </ul> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Physician/provider services, including doctor’s office visits* (continued)</b></p> <ul style="list-style-type: none"> <li>● telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.</li> <li>● virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes <b>if</b> <ul style="list-style-type: none"> <li>○ you’re not a new patient <b>and</b></li> <li>○ the check-in isn’t related to an office visit in the past 7 days <b>and</b></li> <li>○ the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>● Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours <b>if</b> <ul style="list-style-type: none"> <li>○ you’re not a new patient <b>and</b></li> <li>○ the evaluation isn’t related to an office visit in the past 7 days <b>and</b></li> <li>○ the evaluation doesn’t lead to an office visit within 24 hours or the soonest available appointment</li> </ul> </li> <li>● Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you’re not a new patient</li> <li>● Second opinion by another network provider before surgery</li> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Physician/provider services, including doctor’s office visits* (continued)</b></p> <ul style="list-style-type: none"> <li>● Non-routine dental care. Covered services are limited to:                             <ul style="list-style-type: none"> <li>○ surgery of the jaw or related structures</li> <li>○ setting fractures of the jaw or facial bones</li> <li>○ pulling teeth before radiation treatments of neoplastic cancer</li> <li>○ services that would be covered when provided by a physician</li> </ul> </li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>
<p><b>Podiatry services*</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>● diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</li> <li>● routine foot care for members with conditions affecting the legs, such as diabetes</li> </ul> <p>*Authorization rules may apply.</p>	<p>\$0</p>
<p> <b>Prostate cancer screening exams</b></p> <p>For men age 50 and over, we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>● a digital rectal exam</li> <li>● a prostate specific antigen (PSA) test</li> </ul>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Prosthetic and orthotic devices and related supplies*</b></p> <p>Prosthetic devices replace all or part of a body part or function. These include but are not limited to:</p> <ul style="list-style-type: none"> <li>● testing, fitting, or training in the use of prosthetic and orthotic devices</li> <li>● colostomy bags and supplies related to colostomy care</li> <li>● enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections</li> <li>● pacemakers</li> <li>● braces</li> <li>● prosthetic shoes</li> <li>● artificial arms and legs</li> <li>● breast prostheses (including a surgical brassiere after a mastectomy)</li> <li>● prostheses to replace all or part of an external facial body part that was removed or impaired as a result of disease, injury, or congenital defect</li> <li>● incontinence cream and diapers</li> </ul> <p>We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to "Vision care" later in this chart for details.</p> <p>*Authorization rules may apply.</p>	<p>\$0</p>



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




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Services that our plan pays for	What you must pay
<p><b>Skilled nursing facility (SNF) care*</b></p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <li>• a semi-private room, or a private room if it is medically necessary</li> <li>• meals, including special diets</li> <li>• nursing services</li> <li>• physical therapy, occupational therapy, and speech therapy</li> <li>• drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors</li> <li>• blood, including storage and administration</li> <li>• medical and surgical supplies given by nursing facilities</li> <li>• lab tests given by nursing facilities</li> <li>• X-rays and other radiology services given by nursing facilities</li> <li>• appliances, such as wheelchairs, usually given by nursing facilities</li> <li>• physician/provider services</li> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Skilled nursing facility (SNF) care* (continued)</b></p> <p>You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan’s amounts for payment:</p> <ul style="list-style-type: none"> <li>• a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care)</li> <li>• a nursing facility where your spouse or domestic partner lives at the time you leave the hospital</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>
<p> <b>Smoking and tobacco use cessation</b></p> <p>If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit:</p> <ul style="list-style-type: none"> <li>• We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling visits.</li> </ul> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</p> <ul style="list-style-type: none"> <li>• We pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</li> </ul>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Supervised exercise therapy (SET)*</b></p> <p>We pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment.</p> <p>Our plan pays for:</p> <ul style="list-style-type: none"> <li>● up to 36 sessions during a 12-week period if all SET requirements are met</li> <li>● an additional 36 sessions over time if deemed medically necessary by a health care provider</li> </ul> <p>The SET program must be:</p> <ul style="list-style-type: none"> <li>● 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication)</li> <li>● in a hospital outpatient setting or in a physician’s office</li> <li>● delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD</li> <li>● under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p><b>Transportation: Non-emergency medical transportation*</b></p> <p>This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.</p> <p>The forms of transportation are authorized when:</p> <ul style="list-style-type: none"> <li>• your medical and/or physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private transportation, <b>and</b></li> <li>• prior authorization may be required, depending on the service</li> </ul> <p>*Authorization rules may apply. Talk to your provider and get a referral.</p> <p>Schedule your transportation at least two business days in advance by calling <b>1-866-612-1256</b> (TTY <b>711</b>). For more information about how to get this service, refer to <b>Chapter 3, Section G1</b>.</p>	<p>\$0</p>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

Services that our plan pays for	What you must pay
<p><b>Transportation: Non-medical transportation</b></p> <p>This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.</p> <p>Transportation is required for the purpose of obtaining needed medical care, including travel to dental appointments and to pick up prescription drugs.</p> <p>This benefit does not limit your non-emergency medical transportation benefit.</p> <p>Coverage also includes:</p> <ul style="list-style-type: none"> <li>● Unlimited trips to and from the gym within a 10-mile radius of your starting address. Transportation must begin or end in Orange County.</li> <li>● Modes of transportation to the gym or grocery store include: <ul style="list-style-type: none"> <li>○ Daily/monthly bus passes</li> <li>○ OC Access vouchers</li> <li>○ Taxi</li> </ul> </li> </ul> <p>Schedule your transportation at least two business days in advance by calling <b>1-866-612-1256 (TTY 711)</b>. For more information about this service, refer to <b>Chapter 3, Section G2</b>.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care given to treat:</p> <ul style="list-style-type: none"> <li>• a non-emergency that requires immediate medical care, <b>or</b></li> <li>• an unforeseen illness, <b>or</b></li> <li>• an injury, <b>or</b></li> <li>• a condition that needs care right away.</li> </ul> <p>If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency).</p> <p>We provide a \$100,000 benefit for emergency and urgent care and emergency transportation received outside the United States. Services are covered worldwide under the same conditions of medical necessity and appropriateness that would have applied if the same services were provided within the United States.</p> <p>You must first pay for medical care received, obtain a discharge summary or equivalent medical documentation and proof of payment, preferably in English and U.S. dollars. Submit the reimbursement request with all supporting documentation to CalOptima Health OneCare Flex Plus and we will review for medical necessity and appropriateness before reimbursement is made.</p>	<p>\$0 copayment for urgently needed services.</p> <p>You pay for your emergency and urgent care and emergency transportation outside of the U.S. and we will reimburse you up to \$100,000 per year.</p>




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Services that our plan pays for	What you must pay
 <p><b>Vision care</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• one routine eye exam every year <b>and</b></li> <li>• up to \$300 for eyeglasses (frames and lenses) or contact lenses every year</li> </ul> <p>We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.</p> <p>For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> <li>• people with a family history of glaucoma</li> <li>• people with diabetes</li> <li>• African-Americans who are age 50 and over</li> <li>• Hispanic Americans who are 65 or over</li> </ul> <p>We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.</p> <p>If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.</p>	<p>\$0 for exam to diagnosis and treat diseases and conditions of the eye (including yearly glaucoma screening).</p> <p>\$0 for routine eye exam (for up to 1 every year).</p> <p>Our plan pays up to \$300 for one (1) pair of eyeglasses (frames and lenses) or contact lenses every year.</p> <p>\$0 copayment for eyeglasses or contact lenses after cataract surgery.</p>



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



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## E. Community Supports

You may get supports under your Individualized Care Plan. Community Supports are medically appropriate and cost-effective alternative services or settings to those covered under the Medi-Cal State Plan. These services are optional for members. If you qualify, these services may help you live more independently. They do not replace benefits that you already receive under Medi-Cal.

Examples of Community Supports that we offer include:

**Housing Transition Navigation Services:** Housing Transition Services assist individuals in obtaining permanent housing. This includes working with a housing navigator to provide support through the housing identification and application process, benefits advocacy, and resource connections.

- To be eligible:
  - Member must be homeless
  - Member is at risk of homelessness and meet one of the following criteria:
    - Has one or more serious chronic conditions
    - Has a serious mental illness
    - Is at risk of institutionalization
    - Is at risk of overdoes
    - Is requiring residential services because of a substance use disorder (SUD)
    - Has a serious emotional disturbance
    - Is receiving Enhanced care Management (ECM)
    - Is a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, a serious mental illness, serious emotional disturbance, and/or the youth has been the victim of trafficking or domestic violence
  - Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System
- Limitations include:
  - Restrictions and limitations for housing transition/navigation services must be identified as reasonable and necessary in the member's Individualized Housing Support Plan.



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Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Housing Deposits:** Housing Deposits assist with identifying, coordinating, securing or funding one-time services and modifications that help someone establish a new home.

- To be eligible:
  - Member must be homeless or at risk of homelessness
  - Member is receiving housing transition navigation services
  - Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System
- Limitations include:
  - Members who have already received housing deposits.
  - Members must also receive housing transition navigation services (at a minimum, the associated tenant screening, housing assessment and Individualized Housing Support Plan) in conjunction with this service.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Housing Tenancy and Sustaining Services:** Housing tenancy and sustaining services connect individuals with the support they need to maintain their permanent home, which may include coaching, assistance with the landlord concerns and early intervention services.

- To be eligible:
  - Member must be homeless or at risk of homelessness
  - Member is receiving housing transition navigation services
  - Member is prioritized for permanent supportive housing or rental subsidy through the Orange County Coordinated Entry System



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- Limitations include:
  - These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed.
  - They are only available for a single duration in the individual's lifetime.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Short-Term Post-Hospitalization Housing:** Short-term post-hospitalization housing provides longer-term housing for members who are experiencing homelessness and have a medical or behavioral health need. This service not only assist in recovery but also gives members time to identify and move into a permanent home.

- To be eligible:
  - Member is exiting recuperative care, inpatient hospital, residential substance uses disorder treatment facility, residential mental health treatment facility, correctional facility or nursing facility
  - Member must be homeless or at risk of homelessness
- Limitations include:
  - This is a once-in-a-lifetime benefit and are not to exceed a duration of six (6) months.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Recuperative Care (Medical Respite):** Recuperative care (medical respite) is short-term housing for individuals experiencing homelessness who are healing from an injury or illness and could benefit from medical oversight while completing their recovery.

- To be eligible:
  - Member must be homeless or at risk of homelessness
  - Member is at risk of hospitalization or is post-hospitalization
  - Member lives alone with no formal supports



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- Limitations include:
  - A member cannot use more than 90 consecutive days of recuperative care.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Respite Services:** Respite services provide much-needed relief and support to caregivers of members who require supervision. These services can be provided in or outside the home and enable caregivers to take a break from their ongoing duties.

- To be eligible:
  - Individuals who live in the community and are compromised in their activities of daily living (ADLs) and therefore dependent upon a qualified caregiver who provides most of their support and who require caregiver relief to avoid institutional placement
- Limitations include:
  - This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Day Habilitation Programs:** Day habilitation programs provide individuals with the skills needed to successfully operate in the community setting, such as developing interpersonal relationships, building daily living skills and using public transportation.

- To be eligible:
  - Member is homeless
  - Member is at risk of homelessness or institutionalization
  - Member left homelessness and entered housing in the past 24 months



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

- Limitations include:
  - Members matching proficient in all categories will be ineligible for this service.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Nursing Facility Transition/Diversion to Assisted Living Facilities:** Nursing facility transition/diversion to assisted living facilities provides supportive services so individuals can move back into a home-like community setting or avoid long-term placement in a nursing facility.

- To be eligible:
  - For Nursing Facility Transition:
    - Has resided 60-plus days in a nursing facility;
    - Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
    - Able to reside safely in an assisted living facility with appropriate and cost-effective supports
  - For Nursing Facility Diversion:
    - Interested in remaining in the community;
    - Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
    - Must be currently medically necessary nursing facility level of care (LOC) or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility
- Limitations include:
  - Members are directly responsible for paying their own living expenses.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

**Community Transition Services/Nursing Facility Transition to a Home:** Community transition services/nursing facility transition to a home provides supportive services and modifications so individuals can move from a nursing facility back into a private residence.

- To be eligible:
  - Currently receiving medically necessary nursing facility LOC services, and in lieu of remaining in the nursing facility or Medical respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
  - Has lived 60-plus days in a nursing home and/or medical respite setting;
  - Interested and agreeable to move back to the community; and
  - Able to reside safely in the community with appropriate and cost-effective supports and services
- Limitations include:
  - Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
  - Community Transition Services are payable up to a total lifetime maximum amount of \$7,500.
  - Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re-institutionalization.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

**Personal Care and Homemaker Services:** Personal care and homemaker services provide for individuals who need support with activities of daily living so that they can continue living independently at home. Typically, this works in tandem with in-home supportive services also provided through Medi-Cal.

- To be eligible:
  - Members at risk for hospitalization, or institutionalization in a nursing facility, or
  - Members with functional deficits and no other adequate support system, or
  - Members approved for In-Home Supportive Services (IHSS) or an application submitted pending social worker assessment and determination of hours
- Limitations include:
  - Members living in facilities such as board and care, assisted living facility (ALF) or nursing facility
  - Members who have not applied for IHSS.
  - Member who has access to reliable caregiver support from family or friends.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Environmental Accessibility Adaptations (Home Modifications):** Environmental accessibility adaptations (home modifications) provide funding for physical adaptations that make it possible for a person to safely continue living independently at home.

- To be eligible:
  - Members at risk for institutionalization in a nursing facility
- Limitations include:
  - If another State Plan service such as Durable Medical Equipment (DME), is available and would accomplish the same goals of independence and avoiding institutional placement.
  - Services must be conducted in accordance with applicable State and local building codes.
  - Services are payable up to a total lifetime maximum of \$7,500.
  - Services do not include aesthetic embellishments.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are general utility to the household.
- Services does not allow for additions to the home to add square footage.
- CalOptima Health must provide the owner and Member with written documentation that the modifications are permanent, and the State is not responsible for maintenance or repair of a modification nor for removal of any medication if the Member ceases to reside at the residence.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Medically Tailored Meals/Medically Supportive Food:** Medically tailored meals/medically supportive food is a service that provides direct food assistance and educational support through the delivery of nutritious meals and groceries to individuals with chronic health conditions.

- To be eligible:
  - Has a qualifying medical condition, such as, but not limited to:
    - Diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes or other high-risk perinatal conditions, and chronic or disabling mental/behavioral health disorders
  - Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement
  - Members with extensive care coordination needs
- Limitations include:
  - Members who do not have access to a refrigerator.
  - Members who are receiving food delivered to their home through another program

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



**Sobering Centers:** Sobering centers are an alternative destination for individuals found to be publicly intoxicated and provide a safe, supportive environment to become sober.

- To be eligible:
  - 18 years of age or older
  - Intoxicated
  - Conscious
  - Cooperative
  - Able to walk
  - Non-violent
  - Free from any medical distress (including life-threatening withdrawal symptoms or apparent underlying symptoms)
  - Agreeable to obtain services
- Limitations include:
  - Under 18 years of age.
  - Medically unstable to remain in this setting

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

**Asthma Remediation:** Asthma remediation provides for physical modifications to a home environment to ensure an individual can continue to live there safely and avoid acute asthma episodes.

- To be eligible:
  - Members with poorly controlled asthma as determined by one of the following:
    - An emergency department visit or hospitalization
    - Two (2) sick urgent care visits in the past 12 months
    - A score of 19 or lower on the Asthma Control Test



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



- Limitations include:
  - Member is participating in another State Plan that would accomplish the same goals of preventing asthma emergencies or hospitalizations.

Members can access this service by requesting a referral through self-referral, referral by a health care provider, or referral by a Community Support provider. Referral forms can be found on CalOptima Health's website at <https://www.caloptima.org/en/About/CurrentInitiatives/CalAIM/ReferralForms>.

If you need help or would like to find out which Community Supports may be available for you, call **1-877-412-2734** (TTY **711**) or call your health care provider.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## F. Benefits covered outside of our plan

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

### F1. California Community Transitions (CCT)

The California Community Transitions (CCT) program uses local Lead Organizations to help eligible Medi-Cal beneficiaries, who have lived in an inpatient facility for at least 90 consecutive days, transition back to, and remaining safely in, a community setting. The CCT program funds transition coordination services during the pre-transition period and for 365 days post transition to assist beneficiaries with moving back to a community setting.

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

#### For CCT transition coordination services

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

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

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

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

#### No change in drug coverage benefit

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## **F2. Medi-Cal Dental**

Certain dental services are available through Medi-Cal Dental. More information is on the [SmileCalifornia.org](https://www.smilecalifornia.org) website. Medi-Cal Dental includes but is not limited to, services such as:

- initial examinations, X-rays, cleanings, and fluoride treatments
- restorations and crowns
- root canal therapy
- partial and complete dentures, adjustments, repairs, and relines

For more information regarding dental benefits available in Medi-Cal Dental, or if you need help finding a dentist who accepts Medi-Cal, contact the customer service line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at [smilecalifornia.org/](https://www.smilecalifornia.org/) for more information.

Our plan offers additional dental services. Refer to the Benefits Chart in **Section D** for more information.

## **F3. Hospice care**

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](https://www.caloptima.org/OneCare).

**For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis**

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

**For drugs that may be covered by our plan's Medicare Part D benefit**

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

**Note:** If you have a serious illness, you may be eligible for palliative care, which provides team-based patient and family-centered care to improve your quality of life. You may receive palliative care at the same time as curative/regular care. Please see Palliative Care section above for more information.

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

**F4. In-Home Supportive Services (IHSS)**

- The IHSS Program will help pay for services provided to you so that you can remain safely in your own home. IHSS is considered an alternative to out-of-home care, such as nursing homes or board and care facilities.
- The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.
- Your personal care coordinator can help you apply for IHSS with your county social service agency. For information, please call IHSS at 1-714-825-3000.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## **F5. 1915(c) Home and Community-Based Services (HCBS) Waiver Programs**

### **Assisted Living Waiver (ALW)**

- The Assisted Living Waiver (ALW) offers Medi-Cal eligible beneficiaries the choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility. The goal of the ALW is to facilitate nursing facility transition back into a homelike and community setting or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility placement.
- Members who are enrolled in ALW can remain enrolled in ALW while also receiving benefits provided by our plan. Our plan works with your ALW Care Coordination Agency to coordinate the services you receive.
- Your personal care coordinator can help you apply for the ALW.

Please see below for a list of local ALW care coordination agencies that service Orange County:

- A-Biz Health Systems  
Phone: 1-818-654-6874
- AARP Care Coordination Agency  
Phone: 1-805-695-3200
- Access TLC Home Health Care  
Phone: 1-818-551-1900 or  
1-800 852-9887
- All Hours Adult Care, SPC  
Phone: 1-844-657-4748
- Anthem Hospice Providers Inc.  
Phone: 1-909-533-4553
- Archangel Home Health Inc.  
Phone: 1-562-861-7047
- Bayview Hospice  
Phone: 1-855-962-4800
- Calstro Hospice, Inc.  
Phone: 1-909-929-7312
- Central Coast Healthcare  
Services  
Phone: 1-888-852-7260
- Concise Home Health Services  
Phone: 1-310-912-3156
- Faith in Angels Hospice  
Phone: 1-818-509-0934
- Grandcare Assisted Living  
Services  
Phone: 1-877-405-6990
- Guidant Care Management  
Phone: 1-844-494-6304
- Home Health Services of  
California  
Phone: 1-213-385-9949
- I Care Hospice, Inc  
Phone: 1-818-238-9188
- Libertana Home Health Care  
Phone: 1-818-902-5000
- Media Home Health  
Phone: 1-818-536-7468
- Prestigious Health Services  
Phone: 1-626-331-7300



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

- River of Light Hospice  
Phone: 1-909-748-7999
- Sierra Hospice Care Inc.  
Phone: 1-213-380-1100
- Star Nursing, Inc.  
Phone: 1-916-542-1445
- The Caring Connection  
Phone: 1-818-368-5007
- True Care Home Health  
Phone: 1-888-944-6248
- Universal Home Care, Inc.  
Phone: 1-323-653-9222
- Victor Valley Home Health  
Services  
Phone: 1-442-327-9060
- Vigilans Home Health Services  
Phone: 1-909-748-7980

**HCBS Waiver for Californians with Developmental Disabilities (HCBS-DD)**

**California Self-Determination Program (SDP) Waiver for Individuals with  
Developmental Disabilities**

- There are two 1915(c) waivers, the HCBS-DD Waiver and SDP Waiver, that provide services to people who have been diagnosed with a developmental disability that begins before the individual's 18th birthday and is expected to continue indefinitely. Both waivers are a way to fund certain services that allow persons with developmental disabilities to live at home or in the community rather than residing in a licensed health facility. Costs for these services are funded jointly by the federal government's Medicaid program and the State of California. Your personal care coordinator can help connect you to DD Waiver services.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

### **Home- and Community-Based Alternative (HCBA) Waiver**

- The HCBA Waiver provides care management services to persons at risk for nursing home or institutional placement. The care management services are provided by a multidisciplinary Care Management Team comprised of a nurse and social worker. The team coordinates Waiver and State Plan services (such as medical, behavioral health, In-Home Supportive Services, etc.), and arranges for other long-term services and supports available in the local community. Care management and Waiver services are provided in the participant's community-based residence. This residence can be privately owned, secured through a tenant lease arrangement, or the residence of a participant's family member.
- Members who are enrolled in the HCBA Waiver can remain enrolled in the HCBA Waiver while also receiving benefits provided by our plan. Our plan works with your HCBA waiver agency to coordinate the services you receive.
- Your personal care coordinator can help you apply for the HCBA.

Please see below for a list of local HCBA care coordination agencies that service Orange County:

- Access TLC  
Phone: 1-800-852-9887
- Libertana Home Health  
Phone: 1-800-750-1444 or  
1-818-902-5000



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

### **Medi-Cal Waiver Program (MCWP)**

- The Medi-Cal Waiver Program (MCWP) provides comprehensive case management and direct care services to persons living with HIV as an alternative to nursing facility care or hospitalization. Case management is a participant centered, team approach consisting of a registered nurse and social work case manager. Case managers work with the participant and primary care provider(s), family, caregiver(s), and other service providers, to assess care needs to keep the participant in their home and community.
- The goals of the MCWP are to: (1) provide home and community-based services for persons with HIV who may otherwise require institutional services; (2) assist participants with HIV health management; (3) improve access to social and behavioral health support and (4) coordinate service providers and eliminate duplication of services.
- Members who are enrolled in the MCWP Waiver can remain enrolled in the MCWP Waiver while also receiving benefits provided by our plan. Our plan works with your MCWP waiver agency to coordinate the services you receive.
- Your personal care coordinator can help you apply for the MCWP.

Please see below for the local MCWP care coordination agency that services Orange County:

- Radiant Health Centers (formerly AIDS Services Foundation)  
Phone: 1-949-809-5700



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



### **Multipurpose Senior Services Program (MSSP)**

- The Multipurpose Senior Services Program (MSSP) provides both social and health care management services to assist individuals remain in their own homes and communities.
- While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases some needed services that are not otherwise available to prevent or delay institutionalization. The total annual combined cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.
- A team of health and social service professionals provides each MSSP participant with a complete health and psychosocial assessment to determine needed services. The team then works with the MSSP participant, their physician, family, and others to develop an individualized care plan. Services include:
  - care management
  - adult day care
  - minor home repair/maintenance
  - supplemental in-home chore, personal care, and protective supervision services
  - respite services
  - transportation services
  - counseling and therapeutic services
  - meal services
  - communication services
- Members who are enrolled in the MSSP Waiver can remain enrolled in the MSSP Waiver while also receiving benefits provided by our plan. Our plan works with your MSSP provider to coordinate the services you receive.
- Your personal care coordinator can help you apply for MSSP

For more information about MSSP or to apply for the program, please call CalOptima Health MSSP at **1-714-347-5780**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## **F6. County Behavioral Health Services Provided Outside Our Plan (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 county behavioral health agencies.

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 your county MHP 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
- peer support services
- community-based mobile crisis intervention services
- intensive care coordination
- intensive home-based services

Drug Medi-Cal Organized Delivery System services are available to you through your county behavioral health agency if you meet criteria to receive these services. Drug Medi-Cal services provided by your county include:

- intensive outpatient treatment services
- perinatal residential substance use disorder treatment
- outpatient treatment services
- narcotic treatment program



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

- medications for addiction treatment (also called Medication Assisted Treatment)
- peer support services
- community-based mobile crisis intervention services

Drug Medi-Cal Organized Delivery System Services include:

- outpatient treatment services
- intensive outpatient treatment services
- partial hospitalization services
- medications for addiction treatment (also called Medication Assisted Treatment)
- residential treatment services
- withdrawal management services
- narcotic treatment program
- recovery services
- care coordination
- peer support services
- community-based mobile crisis intervention services
- contingency management services

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

If you have questions about behavioral health services, authorization for services, screening for level of impairment to determine appropriate services, call CalOptima Health Behavioral Health Line at **1-855-877-3885 (TTY 711)** and choose the CalOptima Health OneCare option.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

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

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

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

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

- services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal, unless listed as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of your *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- meals delivered to your home
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery, and other low-vision aids
- reversal of sterilization procedures
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.
- paramedic services are emergency medical treatments given at the scene by a paramedic. Call your city hall for information on coverage.



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## Chapter 5: Getting your outpatient prescription drugs

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### Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy. They include drugs covered under Medicare Part D and Medi-Cal. **Chapter 6** of your *Member Handbook* tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to **Chapter 5, Section F3**, "In a Medicare-certified hospice program."

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

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

You must have a provider (doctor, dentist, or other prescriber) write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medi-Cal lists.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "*Drug List*" for short. (Refer to **Section B** of this chapter.)

- If it is not on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.



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- Please also note that the request to cover your prescribed drug will be evaluated under both Medicare and Medi-Cal standards.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your prescriber may be able to help identify medical references to support the requested use of the prescribed drug. Drugs covered by Medi-Cal Rx used to treat conditions not supported by the Food and Drug Administration (FDA) or reference books are called “off-label” indications. Drugs used for “off-label” indications are not medically accepted indications and thus not a covered benefit unless: the “off-label” use is described in peer-reviewed literature, and the drug is medically necessary. Medi-Cal Rx defines medically necessary to mean the drug is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Your drug may require approval before we will cover it. Refer to **Section C** in this chapter.

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### A. Getting your prescriptions filled

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

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

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

#### A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for our share of the cost of your covered prescription drug. You may need to pay the pharmacy a copay when you pick up your prescription.

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

If you don't have your Member ID Card or BIC with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back for our share. **If you can't pay for the drug, contact Customer Service right away.** We will do everything we can to help.

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

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

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

If you need help changing your network pharmacy, contact Customer Service.

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

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



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

### **A5. Using a specialized pharmacy**

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
  - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
  - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Customer Service.
- Pharmacies that serve the Indian Health Care Provider (IHCP) and Urban Indian Organization (UIO) Pharmacies Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

### **A6. Using mail-order services to get your drugs**

Our plan does **not** offer mail-order services.



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### A7. Getting a long-term supply of drugs

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

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. In these cases, check with Customer Service first to find out if there's a network pharmacy nearby.

You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

- You are unable to obtain a covered prescription drug in a timely manner within our service area because a network pharmacy is not available or not operational. (For example, a network pharmacy that provides 24-hour service is not available within a reasonable driving distance.)
- You are filling a prescription for a covered drug that is not regularly stocked at an accessible network pharmacy. (For example, a specialized drug.)
- You are traveling outside the service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.
- The prescription drug is for a medical emergency or urgent care, when network pharmacies are not available.
- You are filling a prescription during a declared federal disaster or public health emergency in which you are evacuated or otherwise displaced from your home and unable to access a network pharmacy.

### A9. Paying you back for a prescription



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

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

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

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### **B. Our plan’s Drug List**

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

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

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

#### **B1. Drugs on our *Drug List***

Our *Drug List* includes drugs covered under Medicare Part D.

Most of the prescription drugs you get from a pharmacy are covered by your plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website (<https://medi-calrx.dhcs.ca.gov>) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting your prescriptions through Medi-Cal Rx.

Our *Drug List* includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On our *Drug List*, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives that are called biosimilars. Generally, generic drugs and



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biosimilars work just as well as brand name drugs or original biological products and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Refer to **Chapter 12** for definitions of the types of drugs that may be on the *Drug List*.

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

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

- Visit our plan's website at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare). The *Drug List* on our website is always the most current one.
- Call Customer Service to find out if a drug is on our *Drug List* or to ask for a copy of the list.
- Drugs that are not covered by Part D may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website ([medi-calrx.dhcs.ca.gov/](http://medi-calrx.dhcs.ca.gov/)) for more information.
- Use our "Real Time Benefit Tool" at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare) or call Customer Service. With this tool you can search for drugs on the *Drug List* to get an estimate of what you will pay and if there are alternative drugs on the *Drug List* that could treat the same condition.

### **B3. Drugs not on our *Drug List***

We don't cover all prescription drugs. Some drugs are not on our *Drug List* because the law doesn't allow us to cover those drugs. In other cases, we decided not to include a drug on our *Drug List*.

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

Here are three general rules for excluded drugs:



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

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

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms\*
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride\* preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for the treatment of anorexia, weight loss or weight gain\*
- Outpatient drugs made by a company that says you must have tests or services done only by them

\*Select products may be covered by Medi-Cal. Please visit the Medi-Cal Rx website ([www.medi-calrx.dhcs.ca.gov](http://www.medi-calrx.dhcs.ca.gov)) for more information.

### **B4. Drug List cost-sharing tiers**

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

Tier 1 includes generic drugs. The copay for drugs on this tier is \$0, \$1.60, or \$4.90.

Tier 2 includes brand name drugs. The copay for drugs on this tier is \$0, \$4.80, or \$12.15.

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

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



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## **C. Limits on some drugs**

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

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

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

### **1. Limiting use of a brand name drug or original biological products when respectively, a generic or interchangeable biosimilar version is available**

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

- We usually do not pay for the brand name drug or original biological product when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug, interchangeable biosimilar, or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.
- Your copay may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.

### **2. Getting plan approval in advance**

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

### **3. Trying a different drug first**

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

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



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### 4. Quantity limits

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

To find out if any of the rules above apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Customer Service or check our website at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare). If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the *Member Handbook*.



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### D. Reasons your drug might not be covered

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

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

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

#### D1. Getting a temporary supply

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

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

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



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- You are new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30 days.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
  - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
  - We cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.
- You are moving from one treatment setting to another (this is called a level of care change).
  - Examples of a level of care change include: entering a long-term care facility from an acute-care hospital; discharging from hospital to home; ending a Part A skilled nursing stay with reversion to Part D coverage; giving up hospice status to revert to standard Part A and Part B benefits; ending a long-term care facility stay and returning to the community; and discharging from a psychiatric hospital.
  - If you have a level of care change, we will cover a temporary supply of your drug. This temporary supply will be for up to 30 days. If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30-days of medication. The prescription must be filled at a network pharmacy.



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### D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Customer Service.

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

- Change to another drug.

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

**OR**

- Ask for an exception.

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

### D3. Asking for an exception

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

If you need help asking for an exception, contact Customer Service.



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### E. Coverage changes for your drugs

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

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

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

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

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

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

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

- Check our current *Drug List* online at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare), **or**
- Call Customer Service at the number at the bottom of the page to check our current *Drug List*.

#### Changes we may make to the *Drug List* that affect you during the current plan year

Some changes to the *Drug List* will happen immediately. For example:

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

- We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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- You or your provider can ask for an “exception” from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this handbook for more information on exceptions.
- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or effective or the drug’s manufacturer takes a drug off the market, we may immediately take it off our *Drug List*. If you are taking the drug, we will send you a notice after we make the change. You can work with your doctor or other prescriber to find a different drug that we cover for your condition. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

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

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

### **Changes to the *Drug List* that do not affect you during the current plan year**

We may make changes to drugs you take that are not described above and do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

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

If any of these changes happen for a drug you are taking (except for the changes noted in the section above), the change won’t affect your use until January 1 of the next year.

We will not tell you about these types of changes directly during the current year. You will need to check the *Drug List* for the next plan year (when the list is available during the open enrollment period) to see if there are any changes that will impact you during the next plan year.



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# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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### F. Drug coverage in special cases

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

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

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

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

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

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

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

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

- You may be enrolled in a Medicare hospice and require certain drugs (e.g., pain, anti-nausea drugs, laxative, or anti-anxiety drugs) that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

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

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



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## **G. Programs on drug safety and managing drugs**

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

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

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

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

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

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.



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It's a good idea to talk to your prescriber about your action plan and medication list.

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

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

If you have questions about these programs, contact Customer Service.

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

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

If you use opioid medications that you get from several prescribers or pharmacies or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from certain pharmacies and/or from certain prescribers
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

**You will have a chance to tell us which prescribers or pharmacies you prefer to use and any information you think is important for us to know.** If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Member Handbook*.)



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The DMP may not apply to you if you:

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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

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### **Introduction**

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

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

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

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

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

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

- Our *List of Covered Drugs*.
  - We call this the “*Drug List*.” It tells you:
    - Which drugs we pay for
    - Which of the two tiers each drug is in
    - If there are any limits on the drugs
  - If you need a copy of our *Drug List*, call Customer Service. You can also find the most current copy of our *Drug List* on our website at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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- Most of the prescription drugs you get from a pharmacy are covered by CalOptima Health OneCare Flex Plus. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website ([medi-calrx.dhcs.ca.gov/](http://medi-calrx.dhcs.ca.gov/)) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.
- **Chapter 5** of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
  - When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is provided in "real time," meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call Customer Service for more information.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Member Handbook* for more information about network pharmacies.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, any payments made for your drugs by “Extra Help” from Medicare, employer or union health plans, TRICARE, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what the plan paid, and what other programs or organizations paid for your covered Part D drugs.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information**. This is your total drug costs and total payments made since January 1.
- **Drug price information**. This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- Most of the prescription drugs you get from a pharmacy are covered by the plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit Medi-Cal Rx website ([medi-calrx.dhcs.ca.gov/](http://medi-calrx.dhcs.ca.gov/)) for more information. You can also call the Medi-Cal customer service center at 1-800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.
- To find out which drugs our plan covers, refer to our *Drug List*.

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

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

#### 1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

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

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for our share of the cost of the drug.

Here are some examples of when you should give us copies of your receipts:

- When you buy a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, our plan pays all of the costs of your Medicare Part D drugs for the rest of the year.

### 4. Check the EOBs we send you.

When you get an EOB in the mail, make sure it is complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call CalOptima Health OneCare Flex Plus Customer Service or read the CalOptima Health OneCare Flex Plus *Member Handbook*. You can find a copy of our *Member Handbook* on our website at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

### What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at CalOptima Health OneCare Flex Plus Customer Service. You can also find answers to many questions on our website: [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

### What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at CalOptima Health OneCare Flex Plus Customer Service.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you suspect that a provider who gets Medi-Cal has committed fraud, waste, or abuse, it is your right to report it by calling the confidential toll-free number 1-800-822-6222. Other methods of reporting Medi-Cal fraud may be found at: [www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx](http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx).



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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If you think something is wrong or missing, or if you have any questions, call Customer Service. You can also find answers to many questions on our website: [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare). Keep these EOBs. They are an important record of your drug expenses.

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### C. Drug Payment Stages for Medicare Part D drugs

There are two payment stages for your Medicare Part D prescription drug coverage under our plan. How much you pay depends on which stage you are in when you get a prescription filled or refilled. These are the two stages:

<b>Stage 1: Initial Coverage Stage</b>	<b>Stage 2: Catastrophic Coverage Stage</b>
During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.  You begin in this stage when you fill your first prescription of the year.	During this stage, we pay all of the costs of your drugs through December 31, 2025.  You begin this stage when you have paid a certain amount of out-of-pocket costs.



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### D. Stage 1: The Initial Coverage Stage

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

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

- Tier 1 drugs are generic drugs. The copay is from \$0 to \$4.90, depending on your income.
- Tier 2 drugs are brand name drugs. The copay is \$0 to \$12.15, depending on your income.

#### D1. Your pharmacy choices

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

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

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

To learn more about these choices, refer to **Chapter 5** of your *Member Handbook* and to our *Provider and Pharmacy Directory*.

#### D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 100-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Member Handbook* or our plan's *Provider and Pharmacy Directory*.

#### D3. What you pay

During the Initial Coverage Stage, you may pay a copay each time you fill a prescription. If your covered drug costs less than the copay, you pay the lower price.

Contact Customer Service to find out how much your copay is for any covered drug.



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

	<b>A network pharmacy</b> A one-month or up to a 30-day supply	<b>A network long-term care pharmacy</b> Up to a 31-day supply	<b>An out-of-network pharmacy</b> Up to a 30-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> of your <i>Member Handbook</i> for details.
<b>Cost-sharing Tier 1</b> (generic drugs)	\$0, \$1.60, or \$4.90 depending on the level of "Extra Help" you receive.	\$0, \$1.60, or \$4.90 depending on the level of "Extra Help" you receive.	\$0, \$1.60, or \$4.90 depending on the level of "Extra Help" you receive.
<b>Cost-sharing Tier 2</b> (brand name drugs)	\$0, \$4.80, or \$12.15 depending on the level of "Extra Help" you receive.	\$0, \$4.80, or \$12.15 depending on the level of "Extra Help" you receive.	\$0, \$4.80, or \$12.15 depending on the level of "Extra Help" you receive.

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

### **D4. End of the Initial Coverage Stage**

The Initial Coverage Stage ends when your total out-of-pocket costs reach \$2,000. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your EOB helps you keep track of how much you have paid for your drugs during the year. We let you know if you reach the \$2,000 limit. Many people do not reach it in a year.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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### E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of \$2,000 for your prescription drugs, the Catastrophic Coverage Stage begins. You stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, you pay nothing for your Part D covered drugs.

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

Usually, you pay a copay to cover a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs.

- There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a drug for the first time that is known to have serious side effects).
- If your doctor agrees, you do not pay for the full month's supply for certain drugs.

When you get less than a month's supply of a drug, the amount you pay is based on the number of days of the drug that you get. We calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you get.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a 7 days' supply of the drug, your payment is less than \$0.05 per day multiplied by 7 days, for a total payment less than \$0.35.
- Daily cost-sharing allows you to make sure a drug works for you before you pay for an entire month's supply.
- You can also ask your provider to prescribe less than a full month's supply of a drug to help you:
  - Better plan when to refill your drugs,
  - Coordinate refills with other drugs you take, **and**
  - Take fewer trips to the pharmacy.



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### **G. Prescription cost-sharing assistance for persons with HIV/AIDS**

#### **G1. The AIDS Drug Assistance Program (ADAP)**

The ADAP helps eligible individuals living with HIV/AIDS access life-saving HIV medications. Outpatient Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the California Department of Public Health, Office of AIDS for individuals enrolled in ADAP.

#### **G2. If you are not enrolled in ADAP**

For information on eligibility criteria, covered drugs, or how to enroll in the program, call 1-844-421-7050 or check the ADAP website at [www.cdph.ca.gov/Programs/CID/DOA/Pages/OA\\_adap\\_eligibility.aspx](http://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx).

#### **G3. If you are enrolled in ADAP**

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



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# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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### H. Vaccinations

**Important Message About What You Pay for Vaccines:** Some vaccines are considered medical benefits and are covered under Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to your plan's *List of Covered Drugs (Formulary)* or contact Customer Service for coverage and cost sharing details about specific vaccines.

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

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

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

We recommend that you call Customer Service if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies and providers agree to work with our plan. A network provider works with us to ensure that you have no upfront costs for a Medicare Part D vaccine.

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

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Member Handbook*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's *Drug List*. You may have to pay a copay for Medicare Part D vaccines. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.



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Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
  - For most adult Part D vaccines, you will pay nothing.
  - For other Part D vaccines, you pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
  - You pay a copay to the doctor for the vaccine.
  - Our plan pays for the cost of giving you the shot.
  - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.
3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
  - For most adult Part D vaccines, you will pay nothing for the vaccine itself.
  - For other Part D vaccines, you pay a copay for the vaccine.
  - Our plan pays for the cost of giving you the shot.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## **Chapter 7: Asking us to pay a bill you received for covered services or drugs**

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### **Introduction**

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

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

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

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow CalOptima Health OneCare Flex Plus providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

**If you get a bill for the full cost of health care or drugs, do not pay the bill and send the bill to us.** To send us a bill, refer to **Section B**.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid more than your share of the cost, it is your right to be paid back.
  - If you paid for services covered by Medicare, we will pay you back.
- If you paid for Medi-Cal services you already received, you may qualify to be reimbursed (paid back) if you meet all of the following conditions:
  - The service you received is a Medi-Cal covered service that we are responsible for paying. We will not reimburse you for a service that is not covered by CalOptima Health OneCare Flex Plus.
  - You received the covered service after you became an eligible CalOptima Health OneCare Flex Plus member.
  - You ask to be paid back within one year from the date you received the covered service.
  - You provide proof that you paid for the covered service, such as a detailed receipt from the provider.
  - You received the covered service from a Medi-Cal enrolled provider in CalOptima Health OneCare Flex Plus network. You do not need to meet this condition if you received emergency care, family planning services, or another service that Medi-Cal allows out-of-network providers to perform without pre-approval (prior authorization).
- If the covered service normally requires pre-approval (prior authorization), you need to provide proof from the provider that shows a medical need for the covered service.



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- CalOptima Health OneCare Flex Plus will tell you if they will reimburse you in a letter called a Notice of Action. If you meet all of the above conditions, the Medi-Cal-enrolled provider should pay you back for the full amount you paid. If the provider refuses to pay you back, CalOptima Health OneCare Flex Plus will pay you back for the full amount you paid. We will reimburse you within 45 working days of receipt of the claim. If the provider is enrolled in Medi-Cal, but is not in our network and refuses to pay you back, CalOptima Health OneCare Flex Plus will pay you back, but only up to the amount that FFS Medi-Cal would pay. CalOptima Health OneCare Flex Plus will pay you back for the full out-of-pocket amount for emergency services, family planning services, or another service that Medi-Cal allows to be provided by out-of-network providers without pre-approval. If you do not meet one of the above conditions, we will not pay you back.
- We will not pay you back if:
  - You asked for and received services that are not covered by Medi-Cal, such as cosmetic services.
  - The service is not a covered service for CalOptima Health OneCare Flex Plus.
  - You went to a doctor who does not take Medi-Cal and you signed a form that said you want to be seen anyway and you will pay for the services yourself.
- If we do not cover the services or drugs, we will tell you.

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

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### **1. When you get emergency or urgently needed health care from an out-of-network provider**

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back for our share of the cost. Send us the bill and proof of any payment you made.



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# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

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- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid more than your share of the cost for the Medicare service, we will figure out how much you owed and pay you back for our share of the cost.

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

Network providers must always bill us. It's important to show your Member ID Card when you receive any services or prescriptions; however, sometimes network providers make mistakes, and ask you to pay for your services or more than your share of the costs. **Call Customer Service** at the number at the bottom of this page **if you get any bills**.

- As a plan member, you only pay the copay when you get services we cover. We don't allow providers to bill you more than this amount. This is true even if we pay the provider less than the provider charged for a service. Even if we decide not to pay for some charges, you still do not pay them. Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, but you feel that you paid too much, send us the bill and proof of any payment you made. We will pay you back for the difference between the amount you paid and the amount you owed under our plan.

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

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.



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# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

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

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

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Refer to **Chapter 5** of your *Member Handbook* to learn more about out-of-network pharmacies.
- We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we would pay at an in-network pharmacy.

## 5. When you pay the full Medicare Part D prescription cost because you don't have your Member ID Card with you

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

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

## 6. When you pay the full Medicare Part D prescription cost for a drug that's not covered

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

- The drug may not be on our *List of Covered Drugs (Drug List)* on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Member Handbook*).
  - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Member Handbook*).



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- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the price you paid is higher than our negotiated price for the prescription.

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

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

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### **B. Sending us a request for payment**

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

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

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website ([www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)), or you can call Customer Service and ask for the form.

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

CalOptima Health OneCare Flex Plus Customer Service  
505 City Parkway West  
Orange, CA 92868

For pharmacy claims, mail your request for payment together with any bills or receipts to us at this address:

CalOptima Health OneCare Flex Plus  
Pharmacy Management Reimbursements  
505 City Parkway West  
Orange, CA 92868

**You must submit your claim to us within three (3) years** of the date you got the service, item, or drug.

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# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

## Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

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### C. Coverage decisions

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

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay our share of the cost for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we will pay the provider directly.

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

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

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### D. Appeals

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

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

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



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## Chapter 8: Your rights and responsibilities

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### Introduction

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

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**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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

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

- To get information in a way that you can understand, call your personal care coordinator or Customer Service. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Spanish, Vietnamese, Farsi, Korean, Chinese and Arabic and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Customer Service or write to CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868.
  - To request materials in the available languages and other formats, please call **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free,
  - You can also make a standing request. Your request will be saved in our system for all future mailings and communications, **and**
  - To cancel or make a change to your standing request, please call **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



## **A. Su derecho a recibir servicios e información de manera que cumpla con sus necesidades**

Debemos garantizar que se le brinden **todos** los servicios de manera culturalmente competente y accesible. También debemos informarle sobre los beneficios del plan y sus derechos de manera que usted pueda entenderlos. Debemos informarle sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener información de manera en que pueda entenderla, llame a Servicios para Miembros. Nuestro plan cuenta con servicios de interpretación gratuitos para responder a sus preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en idiomas distintos al inglés, incluyendo español, vietnamita, persa, coreano, chino y árabe, así como en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Miembros o escriba a CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868.
  - Para solicitar materiales en los idiomas disponibles y en otros formatos, llame al **1-877-412-2734 (TTY 711)**, las 24 horas del día, los 7 días de la semana. La llamada es gratuita.
  - También puede hacer una solicitud de manera permanente. Su solicitud será almacenada en nuestro sistema para cualquier correspondencia y comunicados futuros, **y**
  - Para cancelar o cambiar su solicitud permanente, llame al **1-877-412-2734 (TTY 711)**, las 24 horas del día, los 7 días de la semana. La llamada es gratuita.

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## **A. Quyền nhận các dịch vụ và thông tin theo cách có thể đáp ứng các nhu cầu của quý vị**

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

- Để nhận thông tin theo cách quý vị có thể hiểu được, xin gọi cho văn phòng Dịch Vụ. Chương trình của chúng tôi có các dịch vụ thông dịch viên miễn phí để trả lời các thắc mắc bằng những ngôn ngữ khác nhau.
- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị những tài liệu bằng những ngôn ngữ khác ngoài tiếng Anh bao gồm tiếng Tây Ban Nha, tiếng Việt, tiếng Trung Đông, tiếng Hàn Quốc, tiếng Trung Quốc và tiếng Ả rập và bằng các định dạng như chữ in khổ lớn, chữ nổi braille, hoặc đĩa thu thanh. Để nhận tài liệu bằng một trong những định dạng thay thế này, xin gọi cho văn phòng Dịch Vụ hoặc gửi thư đến CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868.
  - Để yêu cầu các tài liệu bằng các ngôn ngữ và định dạng khác hiện có, xin gọi số **1-877-412-2734 (TTY 711)**, 24 giờ một ngày, 7 ngày một tuần. Cuộc gọi này miễn phí,
  - Quý vị cũng có thể thực hiện một yêu cầu thường trực. Yêu cầu của quý vị sẽ được lưu trong hệ thống của chúng tôi cho tất cả các thư từ và thông tin liên lạc trong tương lai, **và**
  - Để hủy bỏ hoặc thay đổi yêu cầu thường trực của quý vị, xin gọi số **1-877-412-2734 (TTY 711)**, 24 giờ một ngày, 7 ngày một tuần. Cuộc gọi này miễn phí.

Nếu quý vị gặp khó khăn khi nhận thông tin từ chương trình của chúng tôi vì vấn đề về ngôn ngữ hoặc tình trạng khuyết tật và quý vị muốn nộp đơn than phiền, xin gọi cho:

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## A. حقوق شما برای دریافت خدمات و اطلاعات به روشی که نیازها شما را برآورده می کند

ما باید اطمینان حاصل کنیم که همه خدمات به روشی که شما ارائه شوند که از لحاظ فرهنگی کارآمد و قابل دسترسی باشند. ما همچنین مزایای برنامه درمانی ما و حقوق شما را به روشی که برایتان قابل درک باشد به شما اطلاع می دهیم. ما باید حقوق شما را در هر سالی که در برنامه درمانی ما عضویت دارید به شما اطلاع دهیم.

- برای دریافت اطلاعات به روشی که برایتان قابل درک باشد، با بخش خدمات مشتریان تماس بگیرید. برنامه درمانی ما برای پاسخگویی به سؤالات شما خدمات مترجم شفاهی را به زبان های گوناگون در دسترس قرار می دهد.

- برنامه ما همچنین میتواند اطلاعات را به زبانهایی غیر از انگلیسی و قالبهایی مانند چاپ درشت، خط بریل طرح ما همچنین می تواند مطالب را به زبانهایی غیر از انگلیسی از جمله اسپانیایی، ویتنامی، فارسی، کره ای، چینی و عربی و در قالبهایی مانند چاپ بزرگ، خط بریل یا صوتی در اختیار شما قرار دهد. برای دریافت مطالب در یکی از این قالبهای جایگزین، لطفاً با خدمات مشتریان تماس بگیرید یا کتبی خود را به CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868 بفرستید.

- برای درخواست مطالب به زبان های موجود و سایر فرمت ها، لطفاً با شماره **1-877-412-2734 (TTY 711)**، در 24 ساعت شبانه روز و 7 روز هفته تماس بگیرید. این تماس رایگان می باشد.

- می توانید یک درخواست دائمی را نیز ارائه کنید. درخواست شما برای مراسلات و مکاتبات در آینده در سیستم ما ذخیره خواهد شد، و

- برای لغو یا ایجاد تغییرات در درخواست دائمی خود، لطفاً با شماره **1-877-412-2734 (TTY 711)**، در 24 ساعت شبانه روز و 7 روز هفته تماس بگیرید. این تماس رایگان می باشد.

اگر به خاطر مشکلات زبانی یا معلولیت در دریافت اطلاعات از برنامه درمانی ما با مشکلاتی مواجه هستید یا می خواهید شکایتی را تسلیم نماید، با این شماره تماس بگیرید:

- Medicare به شماره (1-800-633-4227) 1-800-MEDICARE می توانید در 24 ساعت شبانه روز، 7 روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند.
- دفتر حقوق مدنی Medi-Cal به شماره 1-916-440-7370. کاربران TTY باید با شماره 711 تماس بگیرند.
- سازمان بهداشت و خدمات انسانی ایالات متحده، دفتر حقوق مدنی به شماره 1-800-368-1019. کاربران TTY باید با شماره 1-800-537-7697 تماس بگیرند.



If you have questions, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## A. 귀하의 필요를 충족하는 방법으로 서비스 및 정보를 받을 권리

저희는 모든 서비스가 문화적으로 적절하고, 접근 가능한 방식으로 제공되도록 해야 합니다. 저희는 귀하가 이해할 수 있는 방식으로 플랜의 혜택과 권리에 대해 알려야 합니다. 저희는 귀하가 저희 플랜에 가입되어 있는 한, 매년 귀하의 권리에 대해 알려야 합니다.

- 귀하가 이해할 수 있는 방식으로 정보를 받으려면 개인 관리 코디네이터 또는 고객 서비스에 전화하십시오. 저희 플랜은 다양한 언어로 질문에 답변할 수 있는 무료 통역 서비스를 제공합니다.
- 저희 플랜은 또한 영어 외에도 스페인어, 베트남어, 페르시아어, 한국어, 중국어, 아랍어 등 다른 언어로 된 자료 및 큰글자, 점자 또는 오디오와 같은 다른 형식의 자료를 제공해 드립니다. 이러한 대체 형식 중 하나로 자료를 받으려면 고객 서비스에 전화 하거나 CalOptima Health OneCare Flex Plus 주소 505 City Parkway West, Orange, CA 92868 로 편지를 보내주십시오.
  - 가능한 언어 및 기타 형식의 자료를 요청하려면, 전화번호 **1-877-412-2734 (TTY 711)**로 주 7일 24 시간 연락하십시오. 통화는 무료입니다.
  - 영구적 요청도 가능합니다. 귀하의 요청은 앞으로의 모든 우편물 및 소통을 위해 저희 시스템에 저장됩니다. 또한,
  - 영구 요청을 취소 또는 변경하길 원하시면, 전화번호 **1-877-412-2734 (TTY 711)**번으로 주 7일 24 시간전화주십시오. 통화는 무료입니다.

언어 문제나 장애로 인해 저희 플랜에서 정보를 얻는 데 문제가 있고 불만을 제기하려면:

- Medicare번호 1-800-MEDICARE(1-800-633-4227)로 전화하십시오. 주 7일 24시간 연락이 가능합니다. TTY 사용자는 1-877-486-2048 로 전화하십시오.
- Medi-Cal Office of Civil Rights(시민 권익 사무부) 전화번호는 1-916 440 7370 입니다. TTY 사용자는 전화 711을 이용하십시오.
- Department of Health and Human Services(보건 복지부), Office for Civil Rights (시민 권익 사무부) 번호1-800-368-1019로 연락하십시오. TTY 사용자는 1-800-537-7697 로 전화하십시오.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## A. 您以符合您需求的方式獲取信息的權利

我們必須確保以具有文化能力和可訪問性的方式向您提供**所有**服務。我們必須以您可以理解的方式告訴您有關計畫的福利和您的權利。您在我們計畫中的每一年我們都必須告知您您的權利。

- 若需要以您可以理解的方式獲取信息，請致電客戶服務部。我們的計畫有免費口譯服務，可用於回答不同語言的問題。
- 我們的計畫還可以為您提供英語以外其他語言的資料，包括西班牙語、越南語、波斯語、韓語、中文和阿拉伯語以及大字體、盲文或音頻等格式的資料。要取得這些替代格式之一的資料，請致電客戶服務部或寫信到 CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868。
  - 要索取可用語言和其他格式的材料，請致電**1-877-412-2734 (TTY 711)**，每週 7 天，每天 24 小時。此通電話免費。
  - 您也可以提出長期請求。您的請求將保存在我們的系統中，以供以後所有郵件和通信使用**並且**
  - 要取消或更改您的長期請求，請致電**1-877-412-2734 (TTY 711)**，每週 7 天，每天 24 小時。此通電話免費。

如果您因為語言問題或殘疾而無法從我們的計畫中獲取信息，並且您想提出投訴，請撥打：

- Medicare at 1-800-MEDICARE (1-800-633-4227)。服務時間為每週 7 天，每天 24 小時。TTY 用戶請致電 1-877-486-2048。
- Medi-Cal 民權辦公室電話：1-916-440-7370。TTY 用戶請撥打 711。
- 請致電衛生與公眾服務部，民權辦公室專線 1-800-368-1019。TTY 用戶請撥打 1-800-537-7697。



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## A. حقك في الحصول على الخدمات والمعلومات بالشكل الذي يلبي احتياجاتك

يجب أن نتأكد من تقديم جميع الخدمات لك بطريقة مختصة ثقافيًا وسهلة الوصول إليها. يجب أن نخبرك أيضًا عن مزايا خططنا وحقوقك بطريقة يمكنك فهمها. يجب أن نخبرك بحقوقك كل عام تكون مسجلًا في خططنا.

● للحصول على معلومات بطريقة يمكنك فهمها ، اتصل بخدمة العملاء. تحتوي خططنا على خدمات ترجمة مجانية متاحة للإجابة على الأسئلة بلغات مختلفة.

● يمكن أن توفر لك خططنا أيضًا مواد بلغات أخرى غير الإنجليزية بما في ذلك الإسبانية والفيتنامية والفارسية والكورية والصينية والعربية وبتنسيقات مثل الطباعة الكبيرة أو طريقة برايل أو الصوتيات. للحصول على المواد بأحد هذه التنسيقات البديلة، يرجى الاتصال بخدمة العملاء أو الكتابة إلى .  
CalOptima Health OneCare Flex Plus, 505 City Parkway West, Orange, CA 92868

○ لطلب المواد باللغات المتاحة والتنسيقات الأخرى ، يرجى الاتصال على الرقم **1-877-412-2734** (TTY **711**) ، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. المكالمات مجانية.

○ يمكنك أيضًا تقديم طلب دائم. سيتم حفظ طلبك في نظامنا لجميع المراسلات والاتصالات المستقبلية، و

○ لإلغاء أو إجراء تغيير في طلبك المستديم ، يرجى الاتصال **1-877-412-2734** (TTY **711**) ، 24 ساعة في اليوم ، 7 أيام في الأسبوع. المكالمات مجانية.

إذا كنت تواجه مشكلة في الحصول على معلومات من خططنا بسبب مشاكل لغوية أو إعاقة وتريد تقديم شكوى، فاتصل على:

● Medicare على **1-800-MEDICARE** (1-800-633-4227). يمكنك الاتصال على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع. يجب على مستخدمي TTY الاتصال على **1-877-486-2048**.

● مكتب Medi-Cal للحقوق المدنية على الرقم **1-916-440-7370**. يجب على مستخدمي TTY الاتصال على **711**.

● وزارة الصحة والخدمات الإنسانية الأمريكية ، مكتب الحقوق المدنية على الرقم **1-800-368-1019**. يجب على مستخدمي TTY الاتصال على **1-800-537-7697**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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

You have rights as a member of our plan.

- You have the right to be treated with respect and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information
- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Member Handbook*.
  - Call Customer Service or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women’s health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely services from specialists.
  - If you can’t get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of your *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and personal care coordinator.
- You have the right to make recommendations regarding CalOptima Health OneCare Flex Plus member rights and responsibilities policy.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

- Get information about CalOptima Health Clinical Practice Guidelines (CPGs).
  - Clinical practice guidelines are based on the latest medical research, and they help doctors decide the best course of treatment. You can find the CPGs on our website at <https://www.caloptima.org/en/ForProviders/Resources/ClinicalPracticeGuidelines>.

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

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

We protect your PHI as required by federal and state laws.

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

You have rights when it comes to your information and controlling how your PHI is used. We provide you with a written notice that advises you about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



### **Request confidential communications**

You can ask us to contact you by your preferred method of contact (for example, home or work phone) or to send mail to a different address.

We will consider all fair requests. We must say “yes” if you tell us you would be in danger if we do not.

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

#### **C1. How we protect your PHI**

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

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

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

- We must release PHI to government agencies checking on our plan's quality of care.
- We may release PHI if ordered by a court, but only if it is allowed by California law.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. In most cases, if we use or share your PHI outside of treatment, payment or operations, we must get your written permission first. If you have a preference for how we share your information, please contact us. Please refer to the Notice of Privacy Practices for more information.

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## **D. Our responsibility to give you information**

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Customer Service. This is a free service to you. CalOptima Health OneCare Flex Plus member materials are available in English, Spanish, Vietnamese, Farsi, Korean, Chinese, or Arabic. We can also give you information in large print, braille, data CD or audio.

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
  - put in writing why something is not covered
  - change a decision we made
  - pay for a bill you got



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

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

---

## **F. Your right to leave our plan**

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

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

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

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

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

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

- **Know your choices.** You have the right to be told about all treatment options.
  - **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
  - **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- 



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Member Handbook* tells how to ask us for a coverage decision.

## **G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself**

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

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

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

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

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Customer Service to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. CalOptima Health OneCare Flex Plus will tell you about changes to the state law no later than 90 days after the change.

Call Customer Service for more information.

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

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Ombudsman Office of the California Department of Health Care Services at 1-888-452-8609.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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

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

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

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

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

- Customer Service.
- The Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424. For more details about HICAP, refer to **Chapter 2**.
- The Ombuds Program at 1-888-452-8609. For more details about this program, refer to **Chapter 2** of your *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at [www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf](http://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf).)



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

## **I. Your responsibilities as a plan member**

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

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Customer Service if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Understand your medical needs and participate with your health care providers in developing a mutually agreed-upon treatment plan.
  - Tell CalOptima Health OneCare Flex Plus and your health care providers what we need to know about your medical condition so we can provide care.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your personal care coordinator** including completing an annual health risk assessment.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan

## MEMBER HANDBOOK

### Chapter 8: Your rights and responsibilities

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- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most CalOptima Health OneCare Flex Plus members, Medi-Cal pays for your Medicare Part A premium and for your Medicare Part B premium.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Customer Service.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Member Handbook* advises you about our service area.
  - We can help you find out if you're moving outside our service area.
  - Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2** of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- **Call Customer Service for help if you have questions or concerns.**



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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

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### **Introduction**

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

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

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

You should get the health care, drugs, and long-term services and supports that your doctor and other providers determine are necessary for your care as a part of your care plan. **If you have a problem with your care, you can call the Medicare Medi-Cal Ombuds Program at 1-855-501-3077 for help.** This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2** of your *Member Handbook*.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

Chapter 9: What to do if you have a problem or complaint  
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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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

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

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

### A1. About the legal terms

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

For example, we say:

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

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

---

## B. Where to get help

### B1. For more information and help

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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## Help from the Medicare Medi-Cal Ombuds Program

You can call the Medicare Medi-Cal Ombuds Program and speak with an advocate about your health coverage questions. They offer free legal help. The Ombuds Program is not connected with us or with any insurance company or health plan. Their phone number is 1-855-501-3077, and their website is [www.healthconsumer.org](http://www.healthconsumer.org).

## Help and information from Medicare

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

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website ([www.medicare.gov](http://www.medicare.gov)).

## Help and information from Medi-Cal

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

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

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

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

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

---

## D. Problems with your benefits

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## Is your problem or concern about your benefits or coverage?

This includes problems about whether particular medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems about payment for medical care.

Yes.	No.
My problem is about benefits or coverage. Refer to <b>Section E</b> , "Coverage decisions and appeals."	My problem is not about benefits or coverage. Refer to <b>Section K</b> , "How to make a complaint."

---

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services, and Part B prescription drugs as **medical care**.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from them (refer to **Chapter 4, Section G** of your *Member Handbook*).

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### E2. Appeals

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

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

In most cases, you must start your appeal at Level 1. If your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an IMR Medical Review from the Department of Managed Health Care at [www.dmhc.ca.gov](http://www.dmhc.ca.gov). Refer to **Section F4** for more information.

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

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical care, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals.

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

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Customer Service** at the numbers at the bottom of the page.
- **Medicare Medi-Cal Ombuds Program at 1-855-501-3077.**
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
  - Ask for a legal aid attorney from the Medicare Medi-Cal Ombuds Program at 1-855-501-3077.

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

Call Customer Service at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at <https://www.caloptima.org/en/ForMembers/OneCare/MemberDocuments/CommonForms.aspx>. **You must give us a copy of the signed form.**

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

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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## F. Medical care

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

This section is about your benefits for medical care that is described in **Chapter 4** of your *Member Handbook*. In some cases, different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

### F1. Using this section

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

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

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

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

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

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

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

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

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

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

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

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

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

**What you can do:** You can file a complaint. Refer to **Section K2**.



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## F2. Asking for a coverage decision

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

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

- calling: **1-877-412-2734**, (TTY **711**).
- faxing: **1-714-246-8711**
- writing: CalOptima Health OneCare Flex Plus  
505 City Parkway West,  
Orange, CA 92868.

### Standard coverage decision

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

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

### Fast coverage decision

The legal term for "fast coverage decision" is "**expedited determination.**"

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

- Medical service or item within 72 hours after we get your request, or sooner if your medical condition requires a quicker response.
- Medicare Part B prescription drug within 24 hours after we get your request.

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

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



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**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast coverage decision if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

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

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

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

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

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



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### F3. Making a Level 1 Appeal

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at **1-877-412-2734 (TTY 711)**.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at **1-877-412-2734 (TTY 711)**.

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at <https://www.caloptima.org/en/ForMembers/OneCare/MemberDocuments/CommonForms.aspx>.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
  - We dismiss your request, **and**
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

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

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.



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

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

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

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

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

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



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## There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal, or sooner if your health requires a quicker response**. We will give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter in **Section F4**, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medi-Cal (Medicaid) service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. A State Hearing agency not connected to CalOptima Health OneCare Flex Plus will review your case and make a decision about your appeal. To file a State Hearing, refer to **Section F4**.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal, or sooner if your health requires it.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.

## There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
  - If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter in **Section F4**, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medi-Cal (Medicaid) service or item, you can file a Level 2 – State Hearing with the state yourself as soon as the time is up. A State Hearing agency not connected to CalOptima Health OneCare Flex Plus will review your case and make a decision about your appeal. To file a State Hearing, refer to **Section F4**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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**If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days of the date we got your appeal request, or as fast as your health condition requires and within 72 hours of the date we change our decision, or within 7 calendar days of the date we got your appeal if your request is for a Medicare Part B prescription drug.

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

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

### F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that **Medi-Cal** usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter, in **Section G6**.
- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the IRO. In addition to the automatic Level 2 Appeal, you can also ask for a State Hearing and an Independent Medical Review with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.



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## When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

## If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

## If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

If the IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service**, we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours**, or
  - Provide the service within **5 working days** after we get the IRO's decision for **standard requests**, or
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.



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- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **Within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
  - If your case meets the requirements, you choose whether you want to take your appeal further.
  - There are three additional levels in the appeals process after Level 2, for a total of five levels.
  - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
  - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

## When your problem is about a service or item Medi-Cal usually covers

### (1) State Hearing

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Appeal Decision Letter" notice is mailed to you.

**NOTE:** If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page 225 for more information.



**If you have questions,** please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information,** visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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There are two ways to ask for a State Hearing:

1. You may complete the “Request for State Hearing” on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:
  - To the county welfare department at the address shown on the notice.
  - To the California Department of Social Services:  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-433  
Sacramento, California 94244-2430
  - To the State Hearings Division at fax number 1-916-309-3487 or toll-free at 1-833-281-0903.
2. You can call the California Department of Social Services at 1-800-743-8525. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

The State Hearings Division gives you their decision in writing and explain the reasons.

- If the State Hearings Division says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Hearings Division says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the IRO or State Hearing decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Hearings Division describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.



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### F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for drug categories that require a copay.

If you get a bill that is more than your copay for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you or your provider our share of the cost for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request. If the payment is made to your provider, your provider will then send the payment to you.
- If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.



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If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called “upholding the decision” or “turning down your appeal.” You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Medi-Cal usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

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## G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Medi-Cal may cover. **This section only applies to Medicare Part D drug appeals.** We'll say “drug” in the rest of this section instead of saying “Medicare Part D drug” every time. For drugs covered only by Medi-Cal follow the process in **Section J2**, or you can visit the Medi-Cal Rx website ([medi-calrx.dhcs.ca.gov/](http://medi-calrx.dhcs.ca.gov/)) for more information. You can also call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Member Handbook* for more information about a medically accepted indication.

### G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Medicare Part D drug that is not on our plan's Drug List **or**
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)



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- You ask us if a drug is covered for you (such as when your drug is on our plan’s Drug List but we must approve it for you before we cover it)

**NOTE:** If your pharmacy tells you that your prescription can’t be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a **“coverage determination.”**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
<p>You need a drug that isn’t on our Drug List or need us to set aside a rule or restriction on a drug we cover.</p> <p><b>You can ask us to make an exception.</b> (This is a type of coverage decision.)</p> <p>Start with <b>Section G2</b>, then refer to <b>Sections G3 and G4</b>.</p>	<p>You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.</p> <p><b>You can ask us for a coverage decision.</b></p> <p>Refer to <b>Section G4</b>.</p>	<p>You want to ask us to pay you back for a drug you already got and paid for.</p> <p><b>You can ask us to pay you back.</b> (This is a type of coverage decision.)</p> <p>Refer to <b>Section G4</b>.</p>	<p>We told you that we won’t cover or pay for a drug in the way that you want.</p> <p><b>You can make an appeal.</b> (This means you ask us to reconsider.)</p> <p>Refer to <b>Section G5</b>.</p>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a "**formulary exception.**"

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

### 1. Covering a drug that is not on our *Drug List*.

- If we agree to make an exception and cover a drug that is not on our Drug List, you pay the copay that applies to drugs in tier 2 for brand name drugs or tier 1 for generic drugs. You can't get an exception to the required copay amount for the drug.

### 2. Removing a restriction for a covered drug.

- Extra rules or restrictions apply to certain drugs on our *Drug List* (refer to **Chapter 5** of your *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization (PA)."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.



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### G3. Important things to know about asking for an exception

#### Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our *Drug List* often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request.

#### We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

### G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling **1-877-412-2734** (TTY **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don’t need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a “supporting statement.” The supporting statement includes your doctor or other prescriber’s medical reasons for the exception request.



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- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

### **If your health requires it, ask us for a “fast coverage decision.”**

We use the “standard deadlines” unless we agree to use the “fast deadlines.”

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor’s statement.

A “fast coverage decision” is called an **“expedited coverage determination.”**

You can get a fast coverage decision if:

- It’s for a drug you didn’t get. You can’t get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn’t meet the requirements for a fast coverage decision, we use the standard deadlines instead.
  - We send you a letter that tells you we will use the standard deadline. The letter also tells you how to make a complaint about our decision.
  - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

### **Deadlines for a fast coverage decision**

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor’s supporting statement. We give you our answer sooner if your health requires it.



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- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6**, for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

### **Deadlines for a standard coverage decision about a drug you didn't get**

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### **Deadlines for a standard coverage decision about a drug you already bought**

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.



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## G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan “**redetermination.**”

- Start your **standard** or **fast appeal** by calling **1-877-412-2734** (TTY **711**), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

A fast appeal is also called an “**expedited redetermination.**”

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### Deadlines for a fast appeal at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
  - We give you our answer sooner if your health requires it.
  - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

### Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must send payment to you for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.



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- If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

#### G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

The formal name for the "Independent Review Organization" (IRO) is the "**Independent Review Entity**," sometimes called the "**IRE**."

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file.** If you need help requesting a free copy of your case file, call **1-877-412-2734 (TTY 711)**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

#### Deadlines for a fast appeal at Level 2

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

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.



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- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

### Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.
- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.



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## H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Member Handbook*.

During your covered hospital stay, your doctor and the hospital staff work with you to prepare for the day when you leave the hospital. They also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

Notwithstanding the appeals discussed in this **Section H**, you may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

### H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Customer Service at the numbers at the bottom of the page. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
  - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



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- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
  - You or someone acting on your behalf can sign the notice.
  - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

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

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

- Call Customer Service at the numbers at the bottom of the page
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- Visit [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

## H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the QIO is Livanta, LLC. Call them at 1-877-588-1123 (TTY 1-855-887-6668). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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**Call the QIO before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with you may also file a complaint with CalOptima Health OneCare Flex Plus Grievance and Appeals department.

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

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

**Ask for a fast review.** Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

## What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Customer Service at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal and you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123 (TTY 1-855-887-6668).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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If the QIO says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to **Section F4** to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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## I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that service ends, we stop paying for it.

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

Chapter 9: What to do if you have a problem or complaint  
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## I1. Advance notice before your coverage ends

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

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

## I2. Making a Level 1 Appeal

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

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Customer Service at the numbers at the bottom of the page.
  - Call the HICAP at 1-800-434-0222.
- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

### Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may also file a complaint with CalOptima Health OneCare Flex Plus Grievance and Appeals department.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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

### What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers provide their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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## I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123 (TTY 1-855-887-6668).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

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## J. Taking your appeal beyond Level 2

### J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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## Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
  - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

## Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

## J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the State Hearings Division will tell you what to do if you want to continue the appeals process.

## J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

## Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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## Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

## Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

### K. How to make a complaint

#### K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
<b>Quality of your medical care</b>	<ul style="list-style-type: none"><li>You are unhappy with the quality of care, such as the care you got in the hospital.</li></ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"><li>You think that someone did not respect your right to privacy or shared confidential information about you.</li></ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"><li>A health care provider or staff was rude or disrespectful to you.</li><li>Our staff treated you poorly.</li><li>You think you are being pushed out of our plan.</li></ul>
<b>Accessibility and language assistance</b>	<ul style="list-style-type: none"><li>You cannot physically access the health care services and facilities in a doctor or provider's office.</li><li>Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish).</li><li>Your provider does not give you other reasonable accommodations you need and ask for.</li></ul>
<b>Waiting times</b>	<ul style="list-style-type: none"><li>You have trouble getting an appointment or wait too long to get it.</li><li>Doctors, pharmacists, or other health professionals, Customer Service, or other plan staff keep you waiting too long.</li></ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"><li>You think the clinic, hospital or doctor's office is not clean.</li></ul>



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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Complaint	Example
Information you get from us	<ul style="list-style-type: none"><li>You think we failed to give you a notice or letter that you should have received.</li><li>You think written information we sent you is too difficult to understand.</li></ul>
Timeliness related to coverage decisions or appeals	<ul style="list-style-type: none"><li>You think we don't meet our deadlines for making a coverage decision or answering your appeal.</li><li>You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services.</li><li>You don't think we sent your case to the IRO on time.</li></ul>

**There are different kinds of complaints.** You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call Customer Service at **1-877-412-2734 (TTY 711)**.

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

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

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### K2. Internal complaints

To make an internal complaint, call Customer Service at **1-877-412-2734** (TTY **711**). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar days** after you had the problem you want to complain about.

- If there is anything else you need to do, Customer Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- We will send you a letter within 5 calendar days of receiving your complaint letting you know that we received it and a resolution letter within 30 days of receiving your complaint.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours. If you have an urgent problem that involves an immediate and serious risk to your health, you can request a “fast complaint” and we will respond within 72 hours.

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we don’t make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan

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### K3. External complaints

#### Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). You do not need to file a complaint with CalOptima Health OneCare Flex Plus before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

#### Medi-Cal

**You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.**

#### Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

You may also contact the local OCR office at:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:  
Deputy Director, Office of Civil Rights  
Department of Health Care Services Office of Civil Rights  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413  
Complaint forms are available at  
[http://www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx).
- Electronically: Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov).



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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You may also have rights under the Americans with Disability Act (ADA) and under Section 1557 of the Affordable Care Act. You can contact the Department of Health and Human Services' Office for Civil Rights at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

### QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook*.

In California, the QIO is called Livanta, LLC. The phone number for Livanta, LLC. is 1-877-588-1123 (TTY 1-855-887-6668).



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## **Chapter 10: Ending your membership in our plan**

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### **Introduction**

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Medi-Cal programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan

## MEMBER HANDBOOK

### Chapter 10: Ending your membership in our plan

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#### A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you have some choices to end your membership with our plan any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Medi-Cal or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medi-Cal options and services in **Section C2**.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan

## MEMBER HANDBOOK

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You can get more information about how you can end your membership by calling: Customer Service at the number at the bottom of this page. The number for TTY users is listed too.

- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users can call 1-800-735-2929. For more information or to find a local HICAP office in your area, please visit [www.aging.ca.gov/HICAP](http://www.aging.ca.gov/HICAP). Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Medi-Cal Managed Care Ombudsman at 1-888-452-8609, Monday through Friday from 8:00 a.m. to 5:00 p.m. or e-mail [MMCDOmbudsmanOffice@dhcs.ca.gov](mailto:MMCDOmbudsmanOffice@dhcs.ca.gov).

**NOTE:** If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your *Member Handbook* for information about drug management programs.

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## B. How to end membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 260.
- **Section C** below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



# CalOptima Health OneCare Flex Plus (HMO D-SNP), a Medicare Medi-Cal Plan MEMBER HANDBOOK

Chapter 10: Ending your membership in our plan

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## C. How to get Medicare and Medi-Cal services separately

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

### C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Annual Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan:



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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## 1. You can change to:

**A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It is for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services.**

**Note:** The term Medi-Medi Plan is the name for integrated dual eligible special needs plans (D-SNPs) in California.

## Here is what to do:

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

For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223).

If you need help or more information:

- Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users can call 1-800-735-2929. For more information or to find a local HICAP office in your area, please visit [www.aging.ca.gov/HICAP/](http://www.aging.ca.gov/HICAP/).

## OR

Enroll in a new Medi-Medi Plan.

You are automatically disenrolled from our Medicare plan when your new plan's coverage begins.

Your Medi-Cal plan will change to match your Medi-Medi Plan.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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<p><b>2. You can change to:</b></p> <p><b>Original Medicare with a separate Medicare prescription drug plan</b></p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users can call 1-800-735-2929. For more information or to find a local HICAP office in your area, please visit <a href="http://www.aging.ca.gov/HICAP/">www.aging.ca.gov/HICAP/</a>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare prescription drug plan.</p> <p>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p>
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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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### 3. You can change to:

#### **Original Medicare without a separate Medicare prescription drug plan**

**NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.

You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit [www.aging.ca.gov/HICAP/](http://www.aging.ca.gov/HICAP/).

### **Here is what to do:**

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

If you need help or more information:

- Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users can call 1-800-735-2929. For more information or to find a local HICAP office in your area, please visit [www.aging.ca.gov/HICAP/](http://www.aging.ca.gov/HICAP/).

You are automatically disenrolled from our plan when your Original Medicare coverage begins.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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<p><b>4. You can change to:</b></p> <p><b>Any Medicare health plan</b> during certain times of the year including the <b>Annual Enrollment Period</b> and the <b>Medicare Advantage Open Enrollment Period</b> or other situations described in <b>Section A</b>.</p>	<p><b>Here is what to do:</b></p> <p>Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.</p> <p>For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223).</p> <p>If you need help or more information:</p> <ul style="list-style-type: none"><li>• Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users can call 1-800-735-2929. For more information or to find a local HICAP office in your area, please visit <a href="http://www.aging.ca.gov/HICAP/">www.aging.ca.gov/HICAP/</a>.</li></ul> <p><b>OR</b></p> <p>Enroll in a new Medicare plan.</p> <p>You are automatically disenrolled from our Medicare plan when your new plan's coverage begins.</p> <p>Your Medi-Cal Plan may change.</p>
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## C2. Your Medi-Cal services

For questions about how to get your Medi-Cal services after you leave our plan, contact Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077. Ask how joining another plan or returning to Original Medicare affects how you get your Medi-Cal coverage.

If you have questions about your Medi-Cal benefits, call CalOptima Health Customer Service at **1-888-587-8088** (TTY **711**).



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## **D. Your medical items, services and drugs until your membership in our plan ends**

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies to get your prescriptions filled.
- If you are hospitalized on the day that your membership in CalOptima Health OneCare Flex Plus ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

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## **E. Other situations when your membership in our plan ends**

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is for people who qualify for both Medicare and Medi-Cal.  
**Note:** if you no longer qualify for Medi-Cal you can temporarily continue in our plan with Medicare benefits, please see information below on deeming period.
  - If you lose Medi-Cal eligibility as determined by the State of California, CalOptima Health OneCare Flex Plus will continue to cover your Medicare and prescription drug benefits for six (6) months from the date you lose your Medi-Cal eligibility. If you do not regain your eligibility after six (6) months, we are required to disenroll you.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Customer Service to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

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

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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## **F. Rules against asking you to leave our plan for any health-related reason**

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **call Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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## **G. Your right to make a complaint if we end your membership in our plan**

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

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## **H. How to get more information about ending your plan membership**

If you have questions or would like more information on ending your membership, you can call Customer Service at the number at the bottom of this page.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).



## Chapter 11: Legal notices

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### Introduction

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

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**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free.  
**For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Member Handbook*. The main laws that apply are federal and state laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

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## B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.
- Call the Department of Health Care Services, Office for Civil Rights at 1-916-440-7370. TTY users can call 711 (Telecommunications Relay Service).

If you believe that you have been discriminated against and want to file a discrimination grievance, contact the Grievance and Appeals Resolution Services Discrimination Coordinator

- By Phone: **1-877-412-2734 (TTY 711)**
- In Writing: Attn:  
Grievance and Appeals Resolution Services Discrimination Coordinator  
505 City Parkway West  
Orange, CA 92868
- Website: **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

If your grievance is about discrimination in the Medi-Cal program, you can also file a complaint with the Department of Health Care Services, Office of Civil Rights, by phone, in writing, or electronically:

- By phone: Call 1-916-440-7370. If you cannot speak or hear well, please call 711 (Telecommunications Relay Service).
- In writing: Fill out a complaint form or send a letter to:  
Deputy Director, Office of Civil Rights  
Department of Health Care Services  
Office of Civil Rights  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413  
Complaint forms are available at:  
[www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)
- Electronically: Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov)

If you have a disability and need help accessing health care services or a provider, call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

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

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

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

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).

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## **D. Notice about Medi-Cal estate recovery**

The Medi-Cal program must seek repayment from probated estates of certain deceased members for Medi-Cal benefits received on or after their 55th birthday. Repayment includes Fee-For-Service and managed care premiums/capitation payments for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the member was an inpatient in a nursing facility or was receiving home and community-based services. Repayment cannot exceed the value of a member's probated estate.

To learn more, go to the Department of Health Care Services' estate recovery website at [www.dhcs.ca.gov/er](http://www.dhcs.ca.gov/er) or call 1-916-650-0590.



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

## Chapter 12: Definitions of important words

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### Introduction

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information**, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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**Activities of daily living (ADL):** The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

**Administrative law judge:** A judge that reviews a level 3 appeal.

**AIDS drug assistance program (ADAP):** A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

**Ambulatory surgical center:** A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

**Appeal:** A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorder services.

**Biological Product:** A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also “Original Biological Product” and “Biosimilar”).

**Biosimilar:** A biological drug that is very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (See “Interchangeable Biosimilar”).

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care plan:** Refer to “Individualized Care Plan.”

**Care Plan Optional Services (CPO Services):** Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Medi-Cal.

**Care team:** Refer to “Interdisciplinary Care Team.”

**Catastrophic coverage stage:** The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent \$2,000 for Part D covered drugs during the year. You pay nothing.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.



**If you have questions,** please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information,** visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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**Community-Based Adult Services (CBAS):** Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

**Comprehensive outpatient rehabilitation facility (CORF):** A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

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

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

**Cost-sharing tier:** A group of drugs with the same copay. Every drug on the List of Covered Drugs (also known as the Drug List) is in one of two cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage decision:** A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services.

**Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

**Covered drugs:** The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

**Covered services:** The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

**Cultural competence training:** Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

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



**If you have questions**, please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. For more information, visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.

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**Department of Health Care Services (DHCS):** The state department in California that administers the Medicaid Program (known as Medi-Cal).

**Drug management program (DMP):** A program that helps make sure members safely use prescription opioids and other frequently abused medications.

**Drug tiers:** Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of two tiers.

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

**Excluded Services:** Services that are not covered by this health plan.

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

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.



**If you have questions,** please call CalOptima Health OneCare Flex Plus at **1-877-412-2734 (TTY 711)**, 24 hours a day, 7 days a week. The call is free. **For more information,** visit **[www.caloptima.org/OneCare](http://www.caloptima.org/OneCare)**.



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**Health Insurance Counseling and Advocacy Program (HICAP):** A program that provides free and objective information and counseling about Medicare. **Chapter 2** of your *Member Handbook* explains how to contact HICAP.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has personal care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment (HRA):** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

**Home health aide:** A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Customer Service if you get any bills you don't understand.

Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.

**In Home Supportive Services (IHSS):** The IHSS Program will help pay for services provided to you so that you can remain safely in your own home. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. The types of services which can be authorized through IHSS are housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired. County social service agencies administer IHSS.



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**Independent review organization (IRO):** An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

**Initial coverage stage:** You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you (or others on your behalf, including “Extra Help” from Medicare) pay your share of the cost.

**Inpatient:** A term used when you are formally admitted to the hospital for skilled medical services. If you’re not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

**Interdisciplinary Care Team (ICT or Care team):** A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

**Integrated D-SNP:** A dual-eligible special needs plan that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are known as full-benefit dually eligible individuals.

**Interchangeable Biosimilar:** A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

**List of Covered Drugs (Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a “formulary”.

**Long-term services and supports (LTSS):** Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don’t have to go to a nursing facility or hospital. LTSS covered by our plan include Community-Based Adult Services (CBAS), also known as adult day health care, Nursing Facilities (NF), and Community Supports. IHSS and 1915(c) waiver programs are Medi-Cal LTSS provided outside our plan.



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**Low-income subsidy (LIS):** Refer to “Extra Help.”

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

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

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal.

**Medi-Cal plans:** Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

**Medicaid (or Medical Assistance):** A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Medi-Cal is the Medicaid program for the State of California.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

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

**Medicare Advantage:** A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

**Medicare Appeals Council (Council):** A council that reviews a level 4 appeal. The Council is part of the Federal government.

**Medicare-covered services:** Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.



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**Medicare diabetes prevention program (MDPP):** A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

**Medicare-Medi-Cal enrollee:** A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

**Medication Therapy Management (MTM):** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.

**Medi-Medi Plan:** A Medicare Medi-Cal Plan (Medi-Medi Plan) is a type of Medicare Advantage plan. It is for people who have both Medicare and Medi-Cal, and combines Medicare and Medi-Cal benefits into one plan. Medi-Medi Plans coordinate all benefits and services across both programs, including all Medicare and Medi-Cal covered services.

**Member (member of our plan, or plan member):** A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.



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**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

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

**Network provider:** “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

**Nursing home or facility:** A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of your *Member Handbook* explains coverage decisions.

**Original Biological Product:** A biological product that has been approved by the Food and Drug Administration (FDA) and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.



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**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out of network pharmacies unless certain conditions apply.

**Out-of-network provider or Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Member Handbook* explains out-of-network providers or facilities.

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

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

**Part A:** Refer to "Medicare Part A."

**Part B:** Refer to "Medicare Part B."

**Part C:** Refer to "Medicare Part C."

**Part D:** Refer to "Medicare Part D."

**Part D drugs:** Refer to "Medicare Part D drugs."

**Personal care coordinator:** One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

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



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

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

**Prior authorization (PA):** An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs* and the rules are posted on our website.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

**Prosthetics and Orthotics:** Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality improvement organization (QIO):** A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.



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**Real Time Benefit Tool:** A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

**Referral:** A referral is your primary care provider's (PCP's) or our approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident, or major operation. Refer to **Chapter 4** of your *Member Handbook* to learn more about rehabilitation services.

**Sensitive services:** Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

**Specialist:** A doctor who provides health care for a specific disease or part of the body.

**Specialized pharmacy:** Refer to **Chapter 5** of your *Member Handbook* to learn more about specialized pharmacies.

**State Hearing:** If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.



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**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

**Urgently needed care:** Care you get for an unforeseen illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you cannot get to them because given your time, place, or circumstances, it is not possible, or it is unreasonable to obtain services from network providers (for example when you are outside the plan's service area and you require medically needed immediate services for an unforeseen condition but it is not a medical emergency).



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## CalOptima Health OneCare Flex Plus Customer Service

<b>CALL</b>	<b>1-877-412-2734</b> Calls to this number are free. 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	<b>711</b> This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 24 hours a day, 7 days a week.
<b>FAX</b>	<b>1-714-246-8711</b>
<b>WRITE</b>	CalOptima Health OneCare Flex Plus Customer Service 505 City Parkway West Orange, CA 92868 OneCarecustomerservice@caloptima.org
<b>WEBSITE</b>	<b><a href="http://www.caloptima.org/OneCare">www.caloptima.org/OneCare</a></b>



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CalOptima Health, A Public Agency  
505 City Parkway West, Orange, CA 92868  
[caloptima.org/OneCare](http://caloptima.org/OneCare)

If you have questions or need help with your health care services, please call CalOptima Health's OneCare Customer Service Department toll-free at **1-877-412-2734**, 24 hours a day, 7 days a week. We have staff who speak your language. TTY users can call **711**. You can also visit our website at [www.caloptima.org/OneCare](http://www.caloptima.org/OneCare).