

# Wellcare Dual Align 129 (HMO D-SNP), your Medicare Medi-Cal Plan *Member Handbook*

January 1, 2023 – December 31, 2023

## Your Health and Drug Coverage under Wellcare by Health Net

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

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through December 31, 2023. It explains health care services, behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports. Long-term services and supports help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Wellcare by Health Net, your Medicare Medi-Cal plan.

ATTENTION: If you speak Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day. The call is free.

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## Arabic-

انتباه: إذا كنت تتحدث اللغة العربية أو الأرمنية أو الكمبودية أو الصينية أو الفارسية أو الكورية أو الروسية أو الإسبانية أو التاجالوجية أو الفيتنامية، فنحن نوفر لك خدمات مساعدة لغوية مجانية. اتصل على الرقم 1-800-431-9007 (TTY: 711). في الفترة الممتدة بين 1 أكتوبر و31 مارس، الممثلون متاحون من الاثنين إلى الأحد، من الساعة 8 صباحًا لغاية الساعة 8 مساءً. وفي الفترة الممتدة بين 1 أبريل و30 سبتمبر، الممثلون متاحون من الاثنين إلى الجمعة، من الساعة 8 صباحًا لغاية الساعة 8 مساءً. والاتصال مجاني.

## Armenian –

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե խոսում եք արաբերեն, հայերեն, կամբոջերեն, չինարեն, պարսկերեն, կորեերեն, ռուսերեն, իսպաներեն, թազալոգ կամ վիետնամերեն լեզուներով, ապա Ձեզ կտրամադրվի անվճար լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-431-9007 (TTY՝ 711): Հոկտեմբերի 1-ից մարտի 31-ն ընկած ժամանակահատվածում ներկայացուցիչները հասանելի են երկուշաբթիից կիրակի, ժամը՝ 8 a.m. - 8 p.m.: Ապրիլի 1-ից սեպտեմբերի 30-ն ընկած ժամանակահատվածում ներկայացուցիչները հասանելի են երկուշաբթիից ուրբաթ օրերին, ժամը՝ 8 a.m. - 8 p.m.: Զանգն անվճար է:

## Cambodian –

ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសា អាវ៉ាប់ អាមេនី ខ្មែរ ចិន ហ្វីលីពីន វៀតណាម តាហ្គាឡុក ឬវៀតណាម សេវាកម្មជំនួយផ្នែកភាសាមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ហៅទៅកាន់លេខ 1-800-431-9007 (TTY: 711)។ រវាងថ្ងៃទី 1 ខែតុលានិងថ្ងៃទី 31 ខែមីនា អ្នកតំណាងអាចរកបានពីថ្ងៃចន្ទដល់ថ្ងៃអាទិត្យ ពីម៉ោង 8 ព្រឹកដល់ម៉ោង 8 យប់។ រវាងថ្ងៃទី 1 ខែមេសានិងថ្ងៃទី 30 ខែកញ្ញា អ្នកតំណាងអាចរកបានពីថ្ងៃចន្ទដល់ថ្ងៃសុក្រ ពីម៉ោង 8 ព្រឹកដល់ម៉ោង 8 យប់។ ការហៅទូរសព្ទនេះ គឺឥតគិតថ្លៃ។

## Chinese –

請注意：我們還提供免費的語言協助服務：阿拉伯語、亞美尼亞語、柬埔寨語、中文、波斯語、韓語、俄語、西班牙語、菲律賓語或越南語。請致電 1-800-431-9007 (TTY：711)。在 10 月 1 日至 3 月 31 日之間，代表的服務時間為週一至週日，上午 8 點至晚上 8 點。在 4 月 1 日至 9 月 30 日之間，代表的服務時間為週一至週五，上午 8 點至晚上 8 點。此為免付費專線。

## Farsi –

توجه: اگر به زبان عربی، ارمنی، کامبوجی، چینی، فارسی، کره ای، روسی، اسپانیایی، تآگالوگ یا ویتنامی صحبت می کنید، خدمات کمک زبان به صورت رایگان در اختیار شما قرار می گیرد. با 1-800-431-9007 (TTY 711) تماس بگیرید. بین 1 اکتبر و 31 مارس، نمایندگان از دوشنبه تا یکشنبه، 8 صبح تا 8 بعد از ظهر در دسترس هستند. بین 1 آوریل و 30 سپتامبر، نمایندگان از دوشنبه تا جمعه، 8 صبح تا 8 بعد از ظهر در دسترس هستند. تماس رایگان است.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8

p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

## Korean –

주의: 아랍어, 아르메니아어, 캄보디아어, 중국어, 페르시아어, 한국어, 러시아어, 스페인어, 타갈로그어 또는 베트남어를 구사하시면, 언어 보조 서비스를 무료로 이용하실 수 있습니다. 1-800-431-9007(TTY: 711)번으로 연락해 주십시오. 상담원과는 10월 1일부터 3월 31일까지는 월요일~일요일, 오전 8시~오후 8시에 통화하실 수 있습니다. 4월 1일부터 9월 30일까지는 월요일~금요일, 오전 8시~오후 8시에 통화하실 수 있습니다. 통화는 무료입니다.

## Russian –

ВНИМАНИЕ: Если вы говорите на арабском, армянском, камбоджийском, китайском, корейском, русском, испанском, тагальском или вьетнамском языках либо фарси, вам доступны бесплатные услуги переводчика. Позвоните по номеру 1-800-431-9007 (TTY: 711). С 1 октября по 31 марта представители доступны с понедельника по воскресенье с 8 a.m. до 8 p.m. С 1 апреля по 30 сентября представители доступны с понедельника по пятницу с 8 a.m. до 8 p.m. Звонок бесплатный.

## Spanish –

ATENCIÓN: Si habla Árabe, Armenio, Camboyano, Chino, Persa, Coreano, Ruso, Español, Tagalo o Vietnamita, disponemos de servicios de asistencia lingüística sin costo alguno para usted. Llame al 1-800-431-9007 (TTY: 711). Entre el 1 de Octubre y el 31 de Marzo, los representantes están disponibles de Lunes a Domingo, de 8 a.m. a 8 p.m. Entre el 1 de Abril y el 30 de Septiembre, los representantes están disponibles de Lunes a Viernes, de 8 a.m. a 8 p.m. La llamada es gratuita.

## Tagalog –

ATENSYON: Kung nagsasalita kayo ng Arabic, Armenian, Cambodian, Chinese, Farsi, Korean, Russian, Spanish, Tagalog, o Vietnamese, mayroon kayong magagamit na mga libreng serbisyo ng tulong sa wika. Tumawag sa 1-800-431-9007 (TTY: 711). Mula Oktubre 1 hanggang Marso 31, available ang mga kinatawan mula Lunes–Linggo, 8 a.m. hanggang 8 p.m. Mula Abril 1 hanggang Setyembre 30, available ang mga kinatawan mula Lunes–Biyernes, 8 a.m. hanggang 8 p.m. Libre ang tawag.

## Vietnamese –

LƯU Ý: Nếu quý vị nói tiếng Ả Rập, tiếng Armenia, tiếng Campuchia, tiếng Trung Quốc, tiếng Ba Tư, tiếng Hàn, tiếng Nga, tiếng Tây Ban Nha, tiếng Tagalog hoặc tiếng Việt, chúng tôi có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi đến số 1 800 431 9007 (TTY: 711). Từ ngày 1 tháng 10 đến 31 tháng 3, nhân viên đại diện sẽ làm việc từ Thứ Hai Chủ Nhật, 8

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a.m. đến 8 p.m. Từ ngày 1 tháng 4 đến 30 tháng 9, nhân viên đại diện sẽ làm việc từ Thứ Hai Thứ Sáu, 8 a.m. đến 8 p.m. Cuộc gọi này được miễn phí.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day. The call is free.

Wellcare by Health Net wants to make sure you understand your health plan information. We can send materials to you in another language or alternate format if you ask for it this way. This is called a “standing request.” We will document your choice.

Please call us if:

- You want to get your materials in Arabic, Armenian, Cambodian (Khmer), Chinese (traditional characters), Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese or in an alternate format. You can ask for one of these languages in an alternate format.
- You want to change the language or format that we send you materials.

If you need help understanding your plan materials, please contact Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.

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## 2023 Wellcare by Health Net *Member Handbook*

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## Disclaimers

- ❖ Wellcare is the Medicare brand for Centene Corporation, an HMO, PPO, PFFS, PDP plan with a Medicare contract and is an approved Part D Sponsor. Our D-SNP plans have a contract with the state Medicaid program. Enrollment in our plans depends on contract renewal.
- ❖ Out-of-network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Member Services number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.
- ❖ Medicare approved Wellcare to provide these benefits as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.
- ❖ Benefits mentioned may be a part of Special Supplemental Benefits for the Chronically Ill. Not all members will qualify.
- ❖ Coverage under Wellcare by Health Net 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.

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## Chapter 1: Getting started as a member

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### Introduction

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

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## A. Welcome to our plan

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

### Experience you can count on

You've enrolled in a health plan you can count on.

Wellcare by Health Net helps more than a million people on Medicare and Medi-Cal get the services they need. We do this by offering easy access to your Medicare and Medi-Cal benefits and services, plus a whole lot more:

- We pride ourselves on providing excellent customer service; this is accomplished by providing focused, positive, personalized attention to you as our member. Our trained Member Services staff will not keep you waiting and can support multiple languages through the use of interpreter services. We will provide you with a "concierge" level of service in helping you navigate through your benefits as we would our own family, this will quickly get the answers you need to access care.
- We've been building high-quality networks of doctors for nearly 25 years. The doctors and specialists in our Wellcare by Health Net network work together in medical groups to make sure you get the care you need, when you need it.
- Your community is our community – We're a Southern California company, so our employees live where you live. We support our local communities with:
  - Health screenings at local health events and community centers
  - No-cost health education classes

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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 older,
- Some people under age 65 with certain disabilities, and

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- People with end-stage renal disease (kidney failure).

## B2. Medi-Cal

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

Each state decides:

- What counts as income and resources,
- Who is eligible,
- What services are covered, **and**
- The cost for services.

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

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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## C. Advantages of our plan

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

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

- You can work with us for **all** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.

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- You have access to a 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 care coordinator.
- Your care team and 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 you may have from the medicines.
  - Your test results are shared with all of your doctors and other providers, as appropriate.

**New members to Wellcare by Health Net:** In most instances you will be enrolled in Wellcare by Health Net for your Medicare benefits the 1st day of the month after you request to be enrolled in Wellcare by Health Net. 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 Wellcare by Health Net. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-431-9007 (TTY: 711) if you have any questions. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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## D. Our plan's service area

Our service area includes these counties in California: Los Angeles, Riverside, San Bernadino, and San Diego.

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

You are eligible for our plan as long as you:

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- Live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
- Are age 21 and older at the time of enrollment, **and**
- Have both Medicare Part A and Medicare Part B, **and**
- Are currently eligible for Medi-Cal and receiving full Medi-Cal benefits, including:
  - Individuals who meet the share of cost provisions
  - Nursing facility residents with a share of cost, **and**
- Are a United States citizen or are lawfully present in the United States.

Call Member Services for more information.

Please note: if you lose your eligibility but can reasonably be expected to regain eligibility within 6 months, then you are still eligible for membership in our plan (Chapter 10, Section E, page 251 tells you about coverage and cost sharing during this period, which is called deemed continued eligibility).

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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 effective enrollment date.

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

We reach out to you to complete the HRA. We can complete the HRA by telephone call, mail or on our website.

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, 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say “existing relationship,” it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.
  - We determine an existing relationship by reviewing your available health information available or information you give us.
  - We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days.
  - You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

**Note:** You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services not included in our plan. You **cannot** make this request for providers of DME, transportation or other ancillary providers.

After the continuity of care period ends, you will need to use doctors and other providers in the Wellcare by Health Net network that are affiliated with your primary care provider’s medical group, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. When you enroll in our plan, you will choose a participating medical group from the Wellcare by Health Net network. You will also choose a PCP from this participating medical group. To choose your PCP, go to our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA) and select a PCP from our plan network. Member Services can also help you choose a PCP. Once you have chosen your PCP call Member Services with your selection. Your PCP must be in our network. Refer to **Chapter 3**, Section D, page 49 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 care coordinator, or other health person that you choose.

A care coordinator is a person trained to help you manage the care you need. You get a 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 care coordinator and care team.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## G2. Care plan

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

Your care plan includes:

- Your health care goals.
- A timeline for getting the services you need.

Your care team meets with you after your health risk assessment. They talk with you about services you need. They also tell you about services you may want to think about getting. Your care plan is based on your needs. Your care team works with you to update your care plan at least every year.

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## H. Monthly plan premium

Our plan has no monthly plan premium.

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## 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**, Section D, page 197 of your *Member Handbook* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Member Handbook* on our website at the web address at the bottom of the page or download it.

The contract is in effect for the months you are enrolled in our plan between January 1, 2023 and December 31, 2023.

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## 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*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





## J1. Your Plan ID Card

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

		[Wellcare By Health Net] [Plan_Contract_PBP] CMS#: [XXXXX-XXX] Effective Date: [MM/DD/YYYY]		[www.wellcare.com/HP URL]	
<b>MEMBER INFORMATION</b> Name: [First MI Last Name] Member ID#: [XXXXXXXX-XXX] Care Coordinator Phone: [X-XXX-XXX-XXXX]		<b>PHARMACY INFORMATION</b>  Prescription Drug Coverage		<b>FOR MEMBERS</b> [[Member Services: X-XXX-XXX-XXXX (TTY: 711)]] [[Mental Health Benefits: X-XXX-XXX-XXXX (TTY: 711)]] [[Nurse Advice Line: X-XXX-XXX-XXXX (TTY: 711)]] [[Transportation: X-XXX-XXX-XXXX (TTY: 711)]] [[Envision Vision (For Members and Members): X-XXX-XXX-XXXX (TTY: 711)]]	
<b>PROVIDER INFORMATION</b> [[PPG Name:]] [[Provider Group Name]] [[PPG Phone:]] [[X-XXX-XXX-XXXX]] PCP Name: [Last, First Name] PCP Phone: [X-XXX-XXX-XXXX] <b>MEMBER CANNOT BE CHARGED</b> PCP/Specialist Office Visit: [\$X]		<b>Rx Claims Processor:</b> [CVS Caremark®] RxBIN: [XXXXXX] RxPCN: [XXXXXX] RxGRP: [XXXXXX] RxID: [XXXXXXXXXX]		<b>FOR PROVIDERS</b>  [[For Member eligibility and Medical prior auth/referrals: X-XXX-XXX-XXXX]] [[Medical Claims:]] [Wellcare By Health Net] [Attn: Claims] [Payor ID: 68069] [P.O. Box 9030 Farmington, MO 63640-9030]  [[Pharmacy prior auth: X-XXX-XXX-XXXX]] [[For help: (PHARMACY USE ONLY) X-XXX-XXX-XXXX]] <b>Submit Part D Drug Claims to:</b> [Wellcare By Health Net] [Attn: Member Reimbursement Dept] [P.O. Box 31577, Tampa, FL 33631-3577]	
<b>FOR EMERGENCIES</b> Dial 911 or go to the nearest Emergency Room (ER).					

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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card. Keep this card in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7**, Section A, page 162 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:

- In-Home Support Services (IHSS)
- County Specialty Mental Health and Substance Use Disorder (SUD) Services
- Multi-Purpose Senior Services Program (MSSP) Services
- Medi-Cal Covered Rx Services or Providers “Medi-Cal Rx”
- Medi-Cal Dental Services “Denti-Cal” Plans
- Home and Community-Based Waiver Services (HCBS)

## 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.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

Both Member Services and the website can give you the most up-to-date information about changes in our network providers and pharmacies. This *Provider and Pharmacy Directory* lists health care professionals (such as doctors, nurse practitioners and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Health and Home Health providers) that you may see as a Wellcare by Health Net member. We also list the pharmacies that you may use to get your prescription drugs. Pharmacies listed in the *Provider and Pharmacy Directory* include Retail, Mail Order, Home Infusion, and Long-Term Care (LTC).

### Definition of network providers

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

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

### Definition of network pharmacies

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

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





### **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**, Section C, page 144 of your *Member Handbook* for more information.

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

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

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

The EOB tells you the total amount you, or others on your behalf, spent on your Part D prescription drugs and the total amount we paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take such as increases in price and other drugs with lower cost sharing that may be available. You can talk to your prescriber about these lower cost options. **Chapter 6**, Section A, page 157 of your *Member Handbook* gives more information about the EOB and how it helps you track your drug coverage.

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

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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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.
- Admission to a nursing home or hospital.
- Care from a hospital or emergency room.
- Changes in your caregiver (or anyone responsible for you)
- You take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services.

### **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**, Section C1, page 183 of your *Member Handbook*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## 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 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 Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## A. Member Services

<b>CALL</b>	<p>1-800-431-9007 This call is free.</p> <p>Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p> <p>We have free interpreter services for people who do not speak English.</p>
<b>TTY</b>	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p>
<b>WRITE</b>	<p>Wellcare by Health Net 7700 Forsyth Boulevard Clayton, MO 63105</p>
<b>WEBSITE</b>	<p><a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a></p>

Contact Member Services to get help with:

- Questions about the plan
- Questions about claims or billing
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services **or**

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- 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**, Section E, page 198 of your *Member Handbook*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- 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**, Section E, page 198 of your *Member Handbook*.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to **Section F**, page 29).
  - You can call us and explain your complaint at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free.
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](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 Ombuds Program by calling 1-855-501-3077 (TTY: 711), Monday through Friday, 9 a.m. to 5 p.m.
  - To learn more about making a complaint about your health care, refer to **Chapter 9**, Section K, page 239 of your *Member Handbook*.
- Coverage decisions about your Medicare covered drugs
  - A coverage decision about your Medicare drugs is a decision about:
    - your benefits and Medicare covered drugs **or**
    - the amount we pay for your Medicare drugs.
  - Non-Medicare covered drugs, such as over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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 800-977-2273.

- For more on coverage decisions about your Medicare prescription drugs, refer to **Chapter 9**, Section G, page 215 of your *Member Handbook*.
- Appeals about your Medicare drugs
  - An appeal is a way to ask us to change a coverage decision.
  - For more on making an appeal about your Medicare prescription drugs, refer to **Chapter 9**, Section G, page 215 of your *Member Handbook*.
- Complaints about your Medicare drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your Medicare prescription drugs.
  - If your complaint is about a coverage decision about your Medicare prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Or you can call 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048) to ask for help.
  - For more on making a complaint about your Medicare prescription drugs, refer to **Chapter 9**, Section K, page 239, of your *Member Handbook*.
- Payment for health care or Medicare drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7**, Section A, page 162 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**, Section E, page 198 of your *Member Handbook*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## B. Your Care Coordinator

A care coordinator is one main person who works with you, with the health plan, and with your doctors and other providers to make sure you get the health care you need.

Member Services can also let you know how you can contact your care coordinator. A care coordinator:

- Helps put together health care services to meet your health care needs.
- Works with you to make your care plan.
- Helps you decide who will be on your care team.
- Gives you information you need to manage your health care.

You can call Member Service if you need help getting in contact with your care coordinator. If you would like to change your care coordinator or have any additional questions, please contact the phone number listed below. You can also call your care coordinator before they contact you. Call the number below and ask to speak to your care coordinator.

<b>CALL</b>	<p>1-800-431-9007 This call is free.</p> <p>Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p> <p>We have free interpreter services for people who do not speak English.</p>
<b>TTY</b>	<p>711 This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





<b>WRITE</b>	Wellcare by Health Net 7700 Forsyth Boulevard Clayton, MO 63105
<b>WEBSITE</b>	<a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a>

Contact your 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 transportation
- Questions about long-term services and supports (LTSS)

LTSS include Community-Based Adult Services (CBAS) and Nursing Facilities (NF).

Sometimes you can get help with your daily health care and living needs.

You might be able to get these services:

- Community-Based Adult Services (CBAS),
- Skilled nursing care,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services, **and**
- Home health care.

### **Community-Based Adult Services (CBAS):**

Medi-Cal members who have a physical, mental or social impairment occurring after age 18, and who may benefit from community-based adult services (CBAS), may be eligible.

Eligible members must meet one of the following criteria:

- Needs that are significant enough to meet nursing facility level of care A (NF-A), such as needing skilled nursing services, skilled nursing observation, medication management, assistance with physical limitations and/or mental limitations, or above

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- A moderate to severe cognitive disability, including moderate to severe Alzheimer's or other dementia
- A developmental disability
- A mild to moderate cognitive disability, including Alzheimer's or dementia and a need for assistance or supervision with two of the following:
  - Bathing
  - Dressing
  - Self-feeding
  - Toileting
  - Ambulation
  - Transferring
  - Medication management
  - Hygiene
- A chronic mental illness or brain injury and a need for assistance or supervision with two of the following:
  - Bathing
  - Dressing
  - Self-feeding
  - Toileting
  - Ambulation
  - Transferring
- Medication management, or need assistance or supervision with one need from the above list and one of the following:
  - Hygiene
  - Money management
  - Accessing resources
  - Meal preparation
  - Transportation
- A reasonable expectation that preventive services will maintain or improve the present level of function (for example, in cases of brain injury due to trauma or infection)
- A high potential for further deterioration and probable institutionalization if CBAS is not available (for example, in cases of brain tumors or HIV-related dementia)

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## Nursing Facilities (NF):

Members must require 24-hour short or long-term medical care as prescribed by a physician to be eligible for Long-Term Care (LTC) or Skilled Nursing Facility (SNF) placement.

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## C. Nurse Advice Call Line

The Wellcare by Health Net Nurse Advice Line is a service that offers toll-free telephonic coaching and nurse advice from trained clinicians that are available 24 hours a day, 7 days a week, 365 days a year. The Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Clinicians provide one-on-one consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the Nurse Advice Line by calling the Wellcare by Health Net Member Services number on the back of their Member ID Card. You can contact the Nurse Advice Call Line with questions about your health or health care.

<b>CALL</b>	1-800-893-5597 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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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## D. Behavioral Health Crisis Line

Managed Health Network (MHN) operates a 24/7 behavioral health crisis line for members requiring this type of assistance. At any point during the call members can ask to speak to a licensed clinician, who can assist them in obtaining the services that they require. Members can access this crisis line by calling the number below.

<b>CALL</b>	<p>1-855-464-3571 This call is free.</p> <p>Licensed Behavioral Health clinicians are available 24 hours a day, 7 days a week, 365 days a year.</p> <p>We have free interpreter services for people who do not speak English.</p>
<b>TTY</b>	<p>711 (National Relay Service). This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Licensed Behavioral Health clinicians are available 24 hours a day, 7 days a week, 365 days a year.</p>

Contact the Behavioral Health Crisis Line for help with:

- Questions about behavioral health and substance abuse services
- Wellcare by Health Net provides you with around the clock access to medical information and advice. When you call, our Behavioral Health specialists will answer your wellness-related questions. If you have an urgent health need but it is not an emergency, you can call our Behavioral Health Crisis Line 24 hours a day, 7 days a week, 365 days a year for behavioral health clinical questions.

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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

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

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

<b>CALL</b>	1-800-434-0222 Monday through Friday, 9:00 a.m. to 5:00 p.m.
<b>TTY</b>	711 (National Relay Service) This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday through Friday, 9:00 a.m. to 5:00 p.m.
<b>WRITE</b>	HICAP Visit <a href="https://cahealthadvocates.org/hicap/">https://cahealthadvocates.org/hicap/</a> for county office locations
<b>WEBSITE</b>	<a href="https://cahealthadvocates.org/hicap/">https://cahealthadvocates.org/hicap/</a>

Contact HICAP for help with:

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

## F. Quality Improvement Organization (QIO)

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



<b>CALL</b>	1-877-588-1123
<b>TTY</b>	1-855-887-6668  This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
<b>WRITE</b>	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
<b>WEBSITE</b>	<a href="http://www.livantaqio.com">www.livantaqio.com</a>

Contact Livanta for help with:

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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## G. Medicare

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

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

<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 hearing or speaking problems. You must have special telephone equipment to call it.
<b>WEBSITE</b>	<u><a href="http://medicare.gov">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 homes, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices.  It includes helpful websites and phone numbers. It also has documents you can print right from your computer.  If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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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, foster care, pregnant women, and individuals with specific diseases such as tuberculosis, breast cancer, or HIV/AIDS. Medi-Cal is financed by state and federal government.

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





## I. The Office of the Ombudsman

The Office of the Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Ombudsman can also help you with service or billing problems. The Office of the Ombudsman will not automatically take sides in a complaint. They consider all sides in an impartial and objective way. It is their job to help develop fair solutions to health care access problems. Their services are free.

<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>	<a href="mailto:MMCDOmbudsmanOffice@dhcs.ca.gov">MMCDOmbudsmanOffice@dhcs.ca.gov</a>
<b>WEBSITE</b>	<a href="http://www.dhcs.ca.gov/services/medical/Pages/MMCDOmbudsman.aspx">www.dhcs.ca.gov/services/medical/Pages/MMCDOmbudsman.aspx</a>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## J. County Social Services

If you need help with your services for which County Social Services provides assistance, such as applicable benefits, contact your local County Social Services Department. See below for your county specific information.

Los Angeles County	
<b>CALL</b>	<p>1-866-613-3777 This call is free.</p> <p>Except holidays:</p> <p>Monday through Friday, 7:30 a.m. to 7:30 p.m.</p> <p>Saturday, 8:00 a.m. to 4:30 p.m.</p>
<b>TTY</b>	<p>711 (National Relay Service)</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Monday through Friday, 7:30 a.m. to 7:30 p.m.</p> <p>Saturday, 8:00 a.m. to 4:30 p.m.</p>
<b>WRITE</b>	<p>For the nearest social services office, refer to <a href="https://dpss.lacounty.gov/en/resources/offices.html">dpss.lacounty.gov/en/resources/offices.html</a> or in your phone book refer to the White Pages under COUNTY GOVERNMENT</p>
<b>WEBSITE</b>	<p><a href="https://dpss.lacounty.gov">dpss.lacounty.gov</a></p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](https://www.wellcare.com/healthnetCA).



Riverside County	
<b>CALL</b>	<p>Administrative Services — (951) 358-3000</p> <p>Non-Emergency Children’s Services — (951) 358-5650</p> <p>Adoption Team — (951) 358-3555</p> <p>Adult Protective Services — (800) 491-7123 This call is free.</p> <p>Self Sufficiency – (877) 410-8827</p> <p>In-Home Supportive Services / Public Authority — 1-888-960-4477 This call is free.</p> <p>Monday through Friday 8 a.m. to 5 p.m.</p>
<b>TTY</b>	<p>711 (National Relay Service)</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>Monday through Friday 8 a.m. to 5 p.m.</p>
<b>WRITE</b>	<p>For the nearest social services office and hours, refer to <a href="https://rivcodpss.org/office-locations">https://rivcodpss.org/office-locations</a> or in your phone book refer to the White Pages under COUNTY GOVERNMENT</p>
<b>WEBSITE</b>	<p><a href="https://rivcodpss.org/">https://rivcodpss.org/</a></p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



San Bernadino County	
<b>CALL</b>	1-909-891-3900 This call is free. Monday through Friday 8:30 a.m. to 5 p.m.
<b>TTY</b>	711 (National Relay Service)  This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.  Monday through Friday 8:30 a.m. to 5 p.m.
<b>WRITE</b>	For the nearest social services office, refer to <a href="http://hss.sbcounty.gov/daas/Contact_Us.aspx">http://hss.sbcounty.gov/daas/Contact_Us.aspx</a> or in your phone book refer to the White Pages under COUNTY GOVERNMENT
<b>WEBSITE</b>	<a href="http://hss.sbcounty.gov/daas/">http://hss.sbcounty.gov/daas/</a>

San Diego County	
<b>CALL</b>	1-800-339-4661. This call is free. Monday through Friday 8:30 a.m. to 5 p.m.
<b>TTY</b>	711 (National Relay Service)  This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.  Monday through Friday 8:30 a.m. to 5 p.m.
<b>WRITE</b>	For the nearest social services office, refer to <a href="https://www.sandiegocounty.gov/content/sdc/hhsa/facilities.html">https://www.sandiegocounty.gov/content/sdc/hhsa/facilities.html</a> or in your phone book refer to the White Pages under COUNTY GOVERNMENT
<b>WEBSITE</b>	<a href="https://www.sandiegocounty.gov/content/sdc/hhsa/facilities.html">https://www.sandiegocounty.gov/content/sdc/hhsa/facilities.html</a>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## K. County Specialty Mental Health Plan

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet the medical necessity criteria.

<b>CALL</b>	<p><b>Los Angeles County Department of Mental Health (DMH) Hotline:</b></p> <p>Urgent: Access Center line 1-800-854-7771 This call is free.</p> <p>Routine: 800-854-7771</p> <p>Substance Use Disorder (SUD): Substance Abuse Service Helpline (SASH) 844-804-7500</p> <p><b>Riverside County Department of Mental Health</b></p> <p>Urgent: CARES Line 800-499-3008 or (951)-509-2499 This call is free.</p> <p>Substance Use Disorder (SUD): Substance Use CARES Line 800-499-3008 ext. 6</p> <p><b>San Bernardino County Department of Behavioral Health</b></p> <p>Urgent: 24/7 Access &amp; Referral Helpline 888-743-1478 or 909-386-8256 This call is free.</p> <p>Substance Use Disorder (SUD): Screening Assessment and Referral Center (SARC)</p> <p>909-421-4601; SUD: 800-968-2636</p> <p><b>San Diego County</b></p> <p>Access &amp; Crisis Line, Referrals 888-724-7240 This call is free.</p> <p>Substance Use Disorder (SUD): 888-724-7240</p> <p>24 hours a day, 7 days a week, 365 days a year</p> <p>We have free interpreter services for people who do not speak English.</p>
<b>TTY</b>	<p>711 (National Relay Service) This call is free.</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p> <p>24 hours a day, 7 days a week, 365 days a year</p>

Contact the county specialty mental health plan for help with:

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Questions about behavioral health services provided by the county
- For free, confidential mental health information, referrals to service providers, and crisis counseling at any day or time, call the Los Angeles Department of Mental Health hotline.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## L. California Department of Managed Health Care

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

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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## M. Other resources

The Health Consumer Alliance Ombuds Program (HCA) offers FREE assistance to help people who are struggling to get or maintain health coverage and resolve problems with their health plans.

If you have problems with:

- Medi-Cal
- Medicare
- Your health plan
- Accessing medical services
- Appealing denied services, drugs, durable medical equipment (DME), mental health services, etc.
- Medical billing
- IHSS (In-Home Supportive Services)

Health Consumer Alliance assists with complaints, appeals, and hearings. The phone number for the Health Consumer Alliance is 1-888-804-3536.

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## N. Area Agencies on Aging

Your local Area Agency on Aging can provide you with information and help coordinate services available to older adults.

<b>CALL</b>	1-800-510-2020 Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
<b>TTY</b>	711 (National Relay Service) This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
<b>WEBSITE</b>	<a href="https://aging.ca.gov/">https://aging.ca.gov/</a>

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





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## O. Department of Health Care Services (DHCS)

As a member of our plan, you are eligible for both Medicare and Medi-Cal (Medicaid). Medi-Cal (Medicaid) is a joint Federal and State government program that helps with medical costs for certain people with limited incomes and resources. If you have questions about the assistance you get from Medi-Cal (Medicaid), contact the Department of Health Care Services (DHCS).

<b>CALL</b>	1-888-452-8609 This call is free  Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
<b>TTY</b>	711 (National Relay Service)  This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.  Monday through Friday, 8:00 a.m. to 5:00 p.m., except holidays
<b>WEBSITE</b>	<a href="http://www.dhcs.ca.gov/individuals">www.dhcs.ca.gov/individuals</a>

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## P. Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



<b>CALL</b>	<p>1-800-772-1213 This call is free.</p> <p>Monday through Friday, 8:00 a.m. to 7:00 p.m.</p> <p>You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week, 365 days a year.</p>
<b>TTY</b>	<p>1-800-325-0778 This call is free.</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Monday through Friday, 8:00 a.m. to 7:00 p.m.</p> <p>You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day, 7 days a week, 365 days a year.</p>
<b>WEBSITE</b>	<p><u><a href="http://www.ssa.gov">www.ssa.gov</a></u></p>

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## 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 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*.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



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Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8  
p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.  
to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 44



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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).  
Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8  
p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.  
to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 45



## A. Information about services and providers

**Services** are health care (such as doctor visits and medical treatment), long-term services and supports (LTSS), supplies, behavioral health services (including mental health and wellness), prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are in **Chapter 4**, Section F, page 133 of your *Member Handbook*. Covered prescription and over-the-counter drugs are in **Chapter 5**, Section B, page 142 of your *Member Handbook*.

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

**Network providers** are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

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## B. Rules for getting services our plan covers

Our plan covers Medicare services and covers or coordinates all Medi-Cal services. This includes behavioral health and long-term services and supports (LTSS).

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

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4**, Section D, page 75 of your *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean important services that are reasonable and protect life. Medically necessary care is needed to keep individuals from getting seriously ill or becoming disabled and reduces severe pain by treating disease, illness, or injury.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another provider. As a plan member, you must choose a network provider to be your PCP.
  - In most cases, your network PCP must give you approval before you can use a provider that is not your PCP or use other providers in our plan's network. This is called a **referral**. If you don't get approval, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 46



- Our plan's PCPs are affiliated with medical groups. When you choose your PCP, you are also choosing the affiliated medical group. This means that your PCP refers you to specialists and services that are also affiliated with their medical group. A medical group is a group of PCPs, specialists, and other health care providers that work together and are contracted to work with our plan.
- You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PCP (for more information about this, refer to section D1, page 49 in this chapter).
- **You must get your care from network providers that are affiliated with your PCP's medical group.** Usually, we won't cover care from a provider who doesn't work with our health plan and your PCP's medical group. This means that you will have to pay the provider in full for the services furnished from providers outside of the network. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information about this, refer to section H, page 63 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. If you are required to see an out-of-network provider, prior authorization (PA) will be required. Once prior authorization is approved, the requesting provider and the accepting provider will be notified of the approval. 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, Section F, page 12** of your *Member Handbook*. If we approve your request, you can continue using the providers you use now for up to 12 months for services. During that time, your care coordinator will contact you to help you find providers in our network that are affiliated with your PCP's medical group. After 12 months, we no longer cover your care if you continue to use providers that are not in our network and not affiliated with your PCP's medical group.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 47



**New members to Wellcare by Health Net:** In most instances you will be enrolled in Wellcare by Health Net for your Medicare benefits the 1st day of the month after you request to be enrolled in Wellcare by Health Net. 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 Wellcare by Health Net. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-431-9007 (TTY: 711), if you have any questions. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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## C. Your care coordinator

### C1. What a care coordinator is

A care coordinator is one main person who works with you, with the health plan, and with your care providers to make sure you get the health care you need. A care coordinator helps put together health care services to meet your health care needs. They work with you to make your care plan. They can help you decide who will be on your care team. Your care coordinator gives you information you need to manage your health care. This will also help you make choices that are right for you. (For more information about this, refer to sections C on page 10 and G1 on page 13 in Chapter 1.)

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

A care coordinator will be assigned to you when you become a plan member. Your care coordinator will contact you when you enroll in our plan. Member Services can also let you know how you can contact your care coordinator. You can call Member Services if you need help getting in contact with your care coordinator.

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

If you would like to change your care coordinator, please contact Member Services.

If you need more help, please call our Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 48





## D. Care from providers

### D1. Care from a primary care provider

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

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

When you become a member of our plan, you must choose a Wellcare by Health Net network provider to be your PCP. Your PCP is a doctor who meets state requirements and is trained to give you basic medical care. These include doctors providing general and/or family medical care, internal medical care, and Obstetrician-Gynecologist (OB/GYNs) who provide care for women.

You will get most of your routine or basic care from your PCP. Your PCP will help you manage the rest of the covered services you get as a member of our plan. This includes:

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

“Coordinating” your covered services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). For certain services, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan or your medical group. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

As we explained above, you will usually see your PCP first for most of your routine health care needs. When your PCP thinks that you need specialized treatment, he or she will need to give you a referral (approval in advance) to see a plan specialist or other certain providers. There are only a few types of covered services you may get without getting approval from your PCP first, as we explain below.

Each Member has a PCP. A PCP can even be a clinic. Women can choose an OB/GYN or

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 49



family planning clinic as their PCP.

You may select a non-physician medical practitioner as your PCP. Non-physician practitioners include: certified nurse midwives, certified nurse practitioners, and physicians assistants. You will be linked to the supervising PCP, but you will continue to receive services from your chosen non-physician practitioner. You are allowed to change your choice of practitioner by changing the supervising PCP. Your ID card will be printed with the name of the supervising PCP. You may be able to have a specialist act as your PCP. Specialists must be willing and able to provide the care you need.

### **Picking a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) as your PCP**

An FQHC or RHC is a clinic and can be your PCP. FQHCs and RHCs are health centers that provide primary care services. Call Member Services for the names and addresses of the FQHCs and RHCs that work with Wellcare by Health Net or look in the *Provider and Pharmacy Directory*.

### **Your choice of PCP**

When you enroll in our plan, you will choose a contracting medical group from our network. A medical group is a group of PCPs, specialists, and other health care providers that work together and are contracted to work with our plan. You will also choose a PCP from this contracting medical group. Your primary care doctor's office should be easy for you to get to. You can ask for a PCP within 10 miles or 30 minutes from where you live or work. Medical groups (and their affiliated PCPs and hospitals) can be found in the *Provider and Pharmacy Directory* or you may visit our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

Each medical group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and hospitals are in the medical group and PCP's network. The name and office telephone number of your PCP is printed on your membership card.

If you do not choose a medical group or PCP or if you chose a medical group or PCP that is not available with this plan, we will automatically assign you to a medical group and PCP near your home.

For information on how to change your PCP, please see “Option to change your PCP” below.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 50



## 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.

Your request will be effective on the first day of the month following the date our plan receives your request. To change your PCP, call Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. or visit our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA) to make your request.

When you contact us, be sure to let us know if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will let you know how you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP and tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

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

## Services you can get without approval from your PCP

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

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

**Note:** Urgently needed care must be immediately needed and medically necessary.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 51



- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations as long as you get them from a network provider.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.
- Family planning services from network providers and out-of-network providers.
- Basic prenatal care, sexually transmitted disease services and HIV testing.

See Chapter 4, Section D, page 75 for details on which covered services may require an approval in advance, such as a referral or prior authorization from your PCP.

## **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.

In order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

Each medical group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. This means that the medical group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your medical group or PCP uses these specialists or hospitals. You **if you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 52



may generally change your PCP at any time if you want to see a plan specialist or go to a hospital that your current PCP can't refer you to. In this chapter, under "Option to change your PCP," we tell you how to change your PCP.

Some types of services will require getting approval in advance from our plan or your medical group (this is called getting "prior authorization"). Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP or other network provider will request the prior authorization from our plan or your medical group. The request will be reviewed, and a decision (organization determination) will be sent to you and your provider. See the Benefits Chart in Chapter 4, Section D, page 75 of this booklet for the specific services that require prior authorization.

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

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- If you 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. For assistance, please contact Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 53



#### **D4. Out-of-network providers**

Out-of-network providers are those that do not have an agreement to work with our plan. Except for emergency care, if there is a certain type of service that you need and that service is not available in our plan's network, you will need to get prior authorization (approval in advance) first. Your PCP will request prior authorization from our plan or your medical group.

It is very important to get approval in advance before you see an out-of-network provider or receive services outside of our network (with the exception of emergency and urgently needed care, family planning services and kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area). If you don't get approval in advance, you may have to pay for these services yourself.

For information on coverage of out-of-network emergency and urgently needed care, please see Section H, page 63 in this chapter.

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

You have access to medically necessary behavioral health services that Medicare and Medi-Cal cover. We provide access to behavioral health services covered by Medicare. Our plan does not provide Medi-Cal covered behavioral health services, but these services are available to you through your local county behavioral health agency.

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

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet criteria to access specialty mental health services. Medi-Cal specialty mental health services provided by your county mental health plan (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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 54



- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management

Medi-Cal or Drug Medi-Cal Organized Delivery System services are available to you through Medi-Cal Fee for Service (FFS) providers if you meet criteria to receive these services. Drug Medi-Cal services are provided by:

County	Agency
Los Angeles	Substance Abuse Prevention and Control (SAPC) Los Angeles County Health Agency
Riverside	Riverside University Health System - Behavioral Health
San Bernardino	San Bernardino County Department of Behavioral Health
San Diego	San Diego County Health and Human Services Behavioral Health Services

Drug Medi-Cal services include:

- Intensive outpatient treatment services
- Residential treatment services
- Outpatient drug free services
- Narcotic treatment services
- Naltrexone services for opioid dependence

Drug Medi-Cal Organized Delivery System Services include:

- Outpatient and intensive outpatient services
- Medications for addiction treatment (also called Medication Assisted Treatment)
- Residential/inpatient
- Withdrawal management
- Narcotic treatment services
- Recovery services

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 55





- Care coordination

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

You will also have access to medically necessary Behavioral Health services that are covered by Medicare and administered through the Wellcare by Health Net Mental Health Network. Behavioral Health services include, but are not limited to:

- Outpatient services: Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to substance use disorder.
- Inpatient services and supplies: Accommodations in a room of two or more beds, including special treatment units, supplies and ancillary services normally provided by the facility.
- Inpatient and alternate levels of care: Partial hospitalization and intensive outpatient services at a Medicare Certified facility.
- Detoxification: Inpatient services for acute detoxification and treatment of acute medical conditions relating to substance use disorder.
- Emergency services: Screening, examination and evaluation to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

For provider information, please look in your Provider and Pharmacy Directory. You may also contact Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. or visit our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

### **Behavioral Health services exclusions and limitations**

For a list of Behavioral Health services exclusions and limitations, please see Chapter 4, Section F, page 133: Benefits *not* covered by our plan, Medicare, or Medi-Cal.

### **Process used to determine medical necessity for Behavioral Health services**

The plan must authorize certain Behavioral Health services and supplies to be covered. For details on services that may require prior authorization, please refer to Chapter 4, Section D, page 75. To get prior authorization for these services, you must call Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The plan will refer you to a **If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 56





nearby contracted mental health professional who will evaluate you to determine if more treatment is needed. If you need treatment, the contracted mental health professional will create a treatment plan and send that plan to Wellcare by Health Net for review. The services included in the treatment plan will be covered when authorized by the plan. If the plan does not approve the treatment plan, no more services or supplies will be covered for that condition. However, the plan may direct you to the county mental health department to assist you in getting the care you need.

**Referral procedures between Wellcare by Health Net and Los Angeles County Department of Mental Health (DMH) and Los Angeles County Department of Public Health (Substance Use Disorder Prevention & Control) (DPH/SAPC), the Riverside County Department of Mental Health, San Bernadino Department of Behavioral Health and San Diego County Behavioral Health Services:**

Referrals for Wellcare by Health Net Behavioral Health services can be made from many sources, including: county Behavioral Health providers, county case managers, PCPs, members and their families. These referring sources can contact Wellcare by Health Net by calling the number that appears on your Member ID Card. Wellcare by Health Net will confirm eligibility and authorize the services when appropriate.

Wellcare by Health Net will work with the county to provide appropriate referral and care coordination for you.

Referrals for County Specialty Mental Health and/or Alcohol & Drug Services may be made directly by you.

Care coordination services include the coordination of services between PCPs, County Behavioral Health providers, county case managers, you, and your family or caregiver, as appropriate.

**What to do if you have a problem or complaint about a Behavioral Health service**

The benefits included in this section are subject to the same appeals process as any other benefit. Refer to Chapter 9, Section K, page 239 for information about making complaints.

**Continuity of care for members who are currently receiving Behavioral Health services**

If you are currently receiving Behavioral Health Services, you can request to keep seeing your provider. We are required to approve this request if you can show an existing relationship with your provider in the 12 months prior to enrollment. If your request is approved, you can continue seeing the provider you see now for up to 12 months. After the first 12 months, we may no longer cover your care if you continue to see the out-of-network provider. For assistance with your request, please call Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 57



a.m. to 8 p.m.

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## F. Transportation services

### F1. Medical transportation of non-emergency situations

You are entitled to non-emergency medical transportation if you have medical needs that don't allow you to use a car, bus, or taxi to your appointments. Non-emergency medical transportation can be provided for covered services such as medical, dental, mental health, substance use, and pharmacy appointments. If you need non-emergency medical transportation, you can talk to your PCP or other provider and ask for it. Your PCP or other provider will decide the best type of transportation to meet your needs. If you need non-emergency medical transportation, they will prescribe it by completing a form and submitting it to Wellcare by Health Net for approval. Depending on your medical need, the approval is good for one year. Your PCP or other provider will reassess your need for non-emergency medical transportation for re-approval every 12 months.

Non-emergency medical transportation is an ambulance, litter van, wheelchair van, or air transport. Wellcare by Health Net 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, Wellcare by Health Net will not pay for an ambulance. You are only entitled to air transport if your medical condition makes any form of ground transportation impossible.

Non-emergency medical transportation must be used when:

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

To ask for medical transportation that your doctor has prescribed for non-urgent **routine appointments**, call Wellcare by Health Net at 1-800-431-9007 (TTY: 711) at least 72 hours in advance (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. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free.

### Medical transportation limits

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 58



Wellcare by Health Net 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, Wellcare by Health Net will help you schedule your transportation. A list of covered services is in Chapter 4, Section D, page 75 of this handbook. Transportation is not covered outside Wellcare by Health Net's network or service area unless pre-authorized.

## F2. Non-medical transportation

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

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

Wellcare by Health Net 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. Wellcare by Health Net uses Access2Care to arrange Medicare covered transportation services and ModivCare to arrange Medi-Cal covered transportation services. 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. Wellcare by Health Net 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 Wellcare by Health Net at 1-800-431-9007 (TTY: 711) at least 72 hours in advance (Monday-Friday) before your appointment. For **urgent appointments**, call as soon as possible. Have your Member ID Card ready when you call. You can also call if you need more information.

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 59



## Non-medical transportation limits

Wellcare by Health Net 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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## G. Covered services in a medical emergency, when urgently needed, or during a disaster

### G1. Care in a medical emergency

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

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

If you have a medical emergency:

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 60



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 will 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 in telling us. Contact Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

### **Covered services in a medical emergency**

If you need an ambulance to get to the emergency room, our plan covers that. To learn more, refer to the Benefits Chart in **Chapter 4**, Section D, page 75 of your *Member Handbook*.

You may get covered emergency medical care outside the United States. This benefit is limited to \$50,000 per year. For more information, see “Worldwide Emergency/Urgent Coverage” in the Benefits Chart in Chapter 4, Section D, page 75 of this booklet or contact Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

### **Getting emergency care if it wasn't an emergency**

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

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

- You use a network provider **or**
- The additional care you get is considered “urgently needed care” and you follow the rules (refer to Section H2) for getting it.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 61



## G2. Urgently needed care

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

### Urgently needed care in our plan's service area

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

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

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

In serious emergency situations: Call "911" or go to the nearest hospital.

If your situation is not so severe: Call your PCP or medical group or, if you cannot call them or you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your medical group or PCP for help.

Your medical group is available 24 hours a day, 7 days a week, 365 days a year to respond to your phone calls regarding medical care that you believe is needed immediately. They will evaluate your situation and give you directions about where to go for the care you need.

If you are not sure whether you have an emergency or require urgent care, our Nurse Advice Line is available to you any time, day or night. You can reach our Nurse Advice Line by calling 1-800-893-5597 (TTY: 711) which is available 24 hours a day, 7 days a week. As a Wellcare by Health Net member, you have access to triage or screening services, 24 hours a day, 7 days a week, 365 days a year. You can also contact Member Services at 1-800-431-9007 (TTY: 711) between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m., if you need help locating a provider. Member Services can also transfer you to the Nurse Advice Line.

### 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 care that you get outside the United States.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 62





Urgently needed services received outside of the United States may be considered an emergency under the worldwide emergency/urgent coverage benefit. For more information, see “Emergency care” in the Benefits Chart in Chapter 4, Section D, page 75 of this booklet.

### **G3. Care during a disaster**

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

Visit our website for information on how to get care you need during a declared disaster:  
[www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

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**, Section A8, page 141 of your *Member Handbook* for more information.

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

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay 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**, Section A, page 162 of your *Member Handbook* to find out what to do.

### **H1. What to do if our plan does not cover services**

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4**, Section D, page 75 of your *Member Handbook*) **and**
- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself.**

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 63



**Chapter 9**, Section E, page 198 of your *Member Handbook* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

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

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

### **I1. 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, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

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

If you want to take part in a Medicare-approved clinical research study, you do **not** need to get approval from us or your primary care provider. Providers that give you care as part of the study do **not** need to be network providers.

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

If you plan to be in a clinical research study, you or your care coordinator should contact Member Services to let us know you will take part in a clinical trial.

### **I2. Payment for services when you are in a clinical research study**

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

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 64





If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

### I3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website ([www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf](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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## J. How your health care services are covered in a religious non-medical health care institution

### J1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution. This benefit is only for Medicare Part A inpatient services (non-medical health care services).

### J2. Care from a religious non-medical health care institution

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

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

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

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

There is unlimited coverage for inpatient hospital care as long as you meet the requirements. **If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 65



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## K. Durable medical equipment (DME)

### K1. DME as a member of our plan

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

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you may acquire ownership of DME as long as it is medically necessary and you have a long-term need for the item. In addition, the item must be authorized, arranged for and coordinated by your PCP, medical group and/or Wellcare by Health Net. Call Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711) to find out about the rental or ownership requirements of durable medical equipment and the documentation you need to provide. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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

If you acquire ownership of a durable medical equipment item while you are a member of our plan, and the equipment requires maintenance, then the provider is allowed to bill the cost of the repair.

### K2. DME ownership if you switch to Original Medicare

If you didn't get ownership of the DME item while in our plan, you must make 13 new consecutive payments after you switch to Original Medicare to own the item. Payments you made while in our plan do **not** count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare **before** you joined our plan, your previous payments don't count toward the 13 consecutive payments. You must make 13 new consecutive payments after you return to Original Medicare to own the item. There are no exceptions to this case when you return to Original Medicare.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 66



### K3. Oxygen equipment benefits as a member of our plan

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

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

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

### K4. Oxygen equipment when you switch to Original Medicare

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

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

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

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

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

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). 67



## 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 Wellcare by Health Net:** In most instances you will be enrolled in Wellcare by Health Net for your Medicare benefits the 1st day of the month after you request to be enrolled in Wellcare by Health Net. 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 Wellcare by Health Net. There will be no gap in your Medi-Cal coverage. Please call us at 1-800-431-9007 (TTY: 711) if you have any questions. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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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**, Section A, page 138. This chapter also explains limits on some services.

Because you get assistance from Medi-Cal, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3**, Section B page 46 of your *Member Handbook* for details about the plan's rules.

If you need help understanding what services are covered, call your care coordinator *and/or* Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

### A1. During public health emergencies

Wellcare by Health Net will follow any and all state and/or federal guidance related to a public health emergency (PHE). During a PHE, the plan will provide all necessary coverage for our members. The coverage may vary depending on the services received and the duration of the PHE. Please visit our website for more information on how to obtain needed care during a PHE at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA) or call Member Services. You can reach Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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## B. Rules against providers charging you for services

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

**You should never get a bill from a provider for covered services.** If you do, refer to **Chapter 7**, Section A, page 162 of your *Member Handbook* or call Member Services.

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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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**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 must provide your Medicare and Medi-Cal covered services according to the rules set by Medicare and Medi-Cal.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be “medically necessary.” Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. A service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to relieve severe pain.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we do **not** pay for care you get from an out-of-network provider. **Chapter 3**, Section D, page 49 of your *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care. In most cases, your PCP must give you approval before you can use a provider that is not your PCP or use other providers in the plan’s network. This is called a referral. **Chapter 3**, Section D, page 49 of your *Member Handbook* has more information about getting a referral and when you do **not** need one.
- You must get care from providers that are affiliated with your PCP’s medical group. Refer to **Chapter 3** Section D, page 49 of your *Member Handbook* for more information.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization. We mark covered services in the Benefits Chart that need prior authorization in italic type.
- If you are within our plan’s 6-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, our Medicare Advantage plan is also responsible for continued coverage of the Medi-Cal benefits that are specified in our plan’s

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8

p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



agreement with your State Medicaid Agency. Medicare cost sharing amounts for Medicare basic and supplemental benefits do not change during this period. The amount you pay depends on the level of Medicaid benefits you have.

#### Important Benefit Information for all Members Participating in Wellness and Health Care Planning (WHP) Services

- Because our plan participates in Value-Based Insurance Design Program, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - If you are unable to make decisions for yourself in the future about your healthcare, medical professionals can make sure your wishes are followed. Advance care planning means having conversations and making decisions about the care you would like in the future.
  - We will assist you with the necessary forms that you need to give someone the legal authority to make medical decisions for you if you ever become unable to make them for yourself.
- You may get advance care planning assistance at any time by contacting our plan.
- WHP and ACP are voluntary and you are free to decline these services

#### Important Benefit Information for Members Who Qualify for “Extra Help”:

- If you receive “Extra Help” to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.
- Please go to the Medical Benefits Chart in Chapter 4, Section D, page 75 for further detail.
- Members qualify for the elimination of their cost sharing for Part D drugs. See Chapter 6 for further detail.

Medicare approved Wellcare by Health Net to provide these benefits as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve Medicare Advantage plans.

- **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:

- **Autoimmune disorders, limited to:**
  - Polyarteritis nodosa (also known as PAN, inflammation and weakening in arteries)

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- Polymyalgia rheumatica (also known as PMR, inflammation/pain/stiffness in shoulders and hips)
- Polymyositis (also known as inflammatory myopathy, muscle weakness)
- Rheumatoid arthritis (also known as RA, pain/stiffness in joints)
- Systemic lupus erythematosus (also known as Lupus)
- **Cancer** (excluding pre-cancer conditions or in-situ (Stage 0) status)
- **Cardiovascular disorders, limited to:**
  - Cardiac arrhythmias (also known as abnormal heart rhythm)
  - Chronic venous thromboembolic disorder (also known as blood clots in the legs)
  - Coronary artery disease (also known as history of chest pains, heart attacks, or hardening of the arteries of the heart)
  - Peripheral vascular disease (also known as hardening of the arteries of the legs)
- **Chronic alcohol or other substance use disorder**
- **Chronic Heart Failure**
- **Chronic lung disorders, limited to:**
  - Asthma
  - Chronic bronchitis
  - Emphysema
  - Pulmonary fibrosis (also known as scarring of lung tissue)
  - Pulmonary hypertension (also known as high blood pressure in the lungs)
- **Chronic and disabling mental health conditions, limited to:**
  - Bipolar disorders
  - Major depressive disorders
  - Paranoid disorder
  - Schizophrenia
  - Schizoaffective disorder
- **Dementia**
- **Diabetes mellitus (also known as Diabetes Type I or Type II)**
- **HIV/AIDS**
- **End-stage liver disease**
- **End-stage renal disease (ESRD) requiring dialysis**
- **Neurologic disorders, limited to:**
  - Amyotrophic lateral sclerosis (ALS)
  - Epilepsy
  - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Huntington's disease
  - Multiple sclerosis (MS)
  - Parkinson's disease
  - Polyneuropathy
  - Spinal stenosis
  - Stroke-related neurologic deficit

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- **Severe hematologic disorders limited to:**
  - Aplastic anemia
  - Chronic venous thromboembolic disorder
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
- **Stroke**
- Your plan includes Special Supplemental Benefits for the Chronically Ill (SSBCI). These supplemental benefits are only offered to high-risk, chronically ill members who also meet additional criteria for eligibility.
- **Members must meet and maintain all three eligibility criteria below to qualify:**
  1. The member must require **intensive** care management.
    - Based on physician assessment of patient having had 2 or more inpatient admissions in the last 60 days **OR** having had 3 or more emergency room visits in the last 60 days.
  2. The member must be at high risk for hospitalization.
    - Based on physician assessment of patient being at high-risk for unplanned hospitalization in the next 60 days.
  3. The member must have a documented and active diagnosis for one or more of the qualifying comorbid and medically complex conditions. The condition must be life threatening or significantly limit the overall health or function of the member.
    - After required office visit, physician to submit claim showing diagnosis code(s) for qualifying eligible condition(s).
- Eligibility is determined at the discretion of your plan through processes that review claims history, risk classification, and other information. Members who cannot be automatically qualified will be required to schedule a visit with their physician to ensure sufficient documentation (e.g. claims, qualifying assessment) are available to validate eligibility.
  1. Confirmation that all criteria has been met is required prior to receiving access to these benefits.
  2. All benefits end on 12/31/2023 and members will be required to re-qualify each plan year.
- For more information, please contact Member Services at the number on the back of your ID card.
- Refer to the “Help with certain chronic conditions” row in the Benefits Chart for more information.
- All preventive services are free. You find this apple 🍏 next to preventive services in the Benefits Chart.
- **Community Supports:** *Community Supports may be available under your Individualized Care Plan.* Community Supports are medically appropriate and cost-effective alternative services or settings. 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 get

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under Medi-Cal. Examples of Community Supports that we offer include medically-supportive food and meals or medically-tailored meals, help for you or your caregiver, or shower grab bars and ramps. If you need help or would like to find out which Community Supports may be available for you, call Member Services at 1-800-431-9007 (TTY: 711), your care coordinator or call your health care provider. Member Services hours are: Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.


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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>	\$0
<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 8 sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year.</p> <p>Acupuncture treatments for chronic low back pain must be stopped if you don't get better or if you get worse.</p> <p style="text-align: center;"><b>This benefit is continued on the next page</b></p>	\$0

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Services that our plan pays for	What you must pay
<p><b>Acupuncture (continued)</b></p> <p>Our plan also covers supplemental (Non-Medicare covered) acupuncture services up to a total of 24 visits every year.</p> <p>In most cases, you must use a contracted provider to receive covered services. Please contact our plan if you have questions on how to use this benefit.</p> <p>Covered acupuncture services include:</p> <ul style="list-style-type: none"> <li>• A new patient exam or an established patient exam for the first evaluation of a patient with a new health issue or new flare-up</li> <li>• Established patient exams (within 3 years of a new exam)</li> <li>• Follow up office visits—may involve acupuncture services or a re-exam</li> <li>• Second opinion with a different provider in the network</li> <li>• Urgent and emergent services.</li> </ul> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency</i></p>	
<p><b>Alcohol misuse screening and counseling</b></p> <p>We pay for one alcohol-misuse screening (SABIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.</p>	\$0

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Services that our plan pays for	What you must pay
<p><b>Ambulance services</b></p> <p>Covered ambulance services include ground, fixed-wing, and rotary-wing (helicopter) ambulance services. The ambulance will take you to the nearest place that can give you care.</p> <p>Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases must be approved by us.</p> <p>In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
<p><b>Annual routine physical exam</b></p> <p>Annual physical exam includes examination of the heart, lung, abdominal and neurological systems, as well as a hands-on examination of the body (such as head, neck and extremities) and detailed medical/family history, in addition to services included in the annual wellness visit.</p>	\$0
<p> <b>Annual wellness visit</b></p> <p>You should get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months.</p>	\$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

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Services that our plan pays for	What you must pay
 <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 older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	\$0
<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 with a doctor's referral.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p> <p><i>You should talk to your provider and get a referral.</i></p>	\$0


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Services that our plan pays for	What you must pay
 <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 to help lower your risk for heart disease. During the visit, 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
 <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 3 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>	\$0

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Services that our plan pays for	What you must pay
<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>Our plan also covers supplemental (Non-Medicare covered) chiropractic services up to 24 visits every year.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
<p> <b>Colorectal cancer screening</b></p> <p>For people 50 and older, we pay for the following services:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> <li>• Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months</li> <li>• DNA based colorectal screening, every 3 years</li> <li>• Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy)</li> <li>• Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months.</li> </ul>	\$0

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Services that our plan pays for	What you must pay
<p><b>Community Based Adult Services (CBAS)</b></p> <p>CBAS is an outpatient, facility-based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. We pay for CBAS if you meet the eligibility criteria.</p> <p><b>Note:</b> If a CBAS facility is not available, we can provide these services separately.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</p>
<p> <b>Counseling to stop smoking or tobacco use</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>If you are pregnant, you may get unlimited tobacco cessation counseling with prior authorization.</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>Certain dental services, including but not limited to, cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program or FFS Medi-Cal.</p> <p><b>Additional services:</b></p> <p>In addition to your Medi-Cal covered dental benefits, our Medicare plan covers additional dental services and procedures. These services may include, but are not limited to, the following:</p> <p>Crowns – noble metals - once per tooth every 5 calendar years</p> <p>Prosthodontics (dentures) – every 2 calendar years per arch</p> <p>Bridges - every 5 calendar years per tooth</p> <p>Exclusions and limitations apply.</p> <p>You can find details about your Medi-Cal dental benefits at <a href="https://smilecalifornia.org">https://smilecalifornia.org</a></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
 <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 referrals.</p>	\$0

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Services that our plan pays for	What you must pay
<div data-bbox="224 279 272 331"></div> <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>Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<div data-bbox="224 279 272 331"></div> <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 Member Services.</li> <li>We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Member Services.</li> </ul> <p>Diabetic glucometer and supplies are limited to OneTouch when obtained at a pharmacy. Other brands are not covered unless pre-authorized.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</p>

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Services that our plan pays for		What you must pay
	<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>	\$0

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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 the last chapter of your <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).”</p> <p>We cover the following items:</p> <ul style="list-style-type: none"> <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>• Enteral pump and supplies</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><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>Durable medical equipment (DME) and related supplies (continued)</b></p> <p>Please contact Member Services to assist you in locating another supplier that may carry the specific item.</p> <p>Non-Medicare covered durable medical equipment for use outside the home is also covered.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	
<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; <b>or</b></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><b>This benefit is continued on the next page</b></p>	<p><b>\$0</b></p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.</p>

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Services that our plan pays for	What you must pay
<p><b>Emergency care (continued)</b></p> <p>Worldwide Emergency/Urgent coverage.</p> <p>Defined as urgent, emergent, and post- stabilization care received outside of the United States.<sup>1</sup></p> <ul style="list-style-type: none"> <li>Limited only to services that would be classified as emergency, urgently needed, or post-stabilization care had they been provided in the United States.<sup>1</sup></li> <li>Ambulance services are covered in situations where getting to the emergency room in any other way could endanger your health.</li> <li>Foreign taxes and fees (including, but not limited to, currency conversion or transaction fees) are not covered.</li> </ul> <p>There is an annual limit of \$50,000 for Worldwide emergency/urgent coverage.</p> <p>United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.</p>	<p><b>\$95</b></p> <p>The worldwide emergency room/urgently needed services visit cost share is not waived if you are admitted for inpatient hospital care.</p>

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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 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>• Counseling and diagnosis of infertility and related services</li> <li>• 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 older to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.)</li> <li>• Genetic counseling</li> </ul> <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>	<p>\$0</p>

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	<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;</li> <li>• Nursing Hotline</li> <li>• Fitness benefit</li> </ul> <p>Our plan provides a membership to a flexible fitness program with monthly credits to use on a variety of larger gyms or local fitness studios.</p> <p>You will have 32 credits each month to utilize. Credits can be used to cover a monthly gym membership with unlimited visits and/or fitness studio classes, at-home fitness boxes and fitness videos. Any unused credits from the monthly allotment do not carry over to the next month.</p> <p>For more information regarding the fitness membership, please call Member Services or visit our website at <a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a>.</p> <ul style="list-style-type: none"> <li>• Personal Emergency Response System (PERS):</li> </ul> <p>Coverage for one personal emergency medical response device per lifetime and the monthly fee. A personal emergency medical response device provides peace of mind and 24/7 response to your emergent and non-emergent needs.</p> <p>Members can choose a traditional "hard-wired" PERS system that is connected via a landline or select a wireless system. For hard-wired systems, an existing landline phone is required.</p> <p>To find out more information call Member Services.</p>	<p>\$0</p>
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Services that our plan pays for	What you must pay
<p><b>Healthy foods card</b></p> <p>Because our plan participates in Value-Based Insurance Design Program, members who qualify will receive the healthy foods card benefit to assist in maintaining a healthy diet. The healthy foods card benefit is a \$50.00 per month allowance to spend on healthy and nutritious foods and produce at participating retailers. You will receive a pre-loaded debit card and the monthly allowance will be available at the beginning of each month. Any unused amount will not carry over into the next month.</p> <p>For more information about grocery items that are covered and participating retailers, and to find out if you qualify, please call Member Services or visit our website at <a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a>.</p>	<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>If you are pregnant or reside in a nursing facility, we also pay for hearing aids, including:</p> <ul style="list-style-type: none"> <li>• Molds, supplies, and inserts</li> <li>• Repairs that cost more than \$25 per repair</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> </ul> <p>Our plan also covers the following supplemental (i.e., routine) hearing services:</p> <ul style="list-style-type: none"> <li>• 1 routine hearing exam every year.</li> <li>• 1 hearing aid fitting and evaluation every year.</li> <li>• 1 non-implantable hearing aid up to \$1000 per ear every year. Limited to 2 non-implantable hearing aids every year. Benefit includes a 1-year standard warranty and 1 package of batteries.</li> </ul> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</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><b>Special Supplemental Benefits for the Chronically III</b></p> <p>Our plan offers additional benefits for certain members at no cost to you. To qualify for these benefits you must meet specific criteria, including having an active diagnosis for one or more qualifying comorbid and medically complex conditions. The condition must be life-threatening or significantly limit the overall health or function of the member. Additionally, the member must require intensive care management and be at high risk for hospitalization. For a complete list of conditions and detailed eligibility criteria, please visit Chapter 4, Section C, page 69.</p> <p>If you feel you meet the criteria and would like to learn more about the below benefits, including how to receive them, please call Member Services.</p> <p>If eligible, you may receive the following benefit(s):</p> <p><b>Utility Flex Card</b></p> <p>If eligible, our plan offers a prepaid Visa debit card with a limit of \$75 per month to help cover the cost of utilities for your home. This benefit is for your use only, may not be sold or transferred, and has no cash value. Any unused Utility Flex Card benefit dollars will expire at the end of each month. The approved utility services for this benefit include:</p> <ul style="list-style-type: none"> <li>• Electric, gas, sanitary, and water utilities</li> <li>• Landline and mobile telephone service</li> <li>• Cable TV service</li> <li>• Certain petroleum expenses, such as home heating oil</li> </ul> <p>If you have not received your prepaid Visa Flex Card, please call Member Services.</p> <p>A reimbursement is available in the event of a card failure, or for use at eligible utility providers that do not accept Visa. You must submit a claim form for reimbursement along with the original printed, itemized receipt from the provider location. Claims must be submitted within 90 days of the date of purchase on your receipt.</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>	\$0
<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.</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><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency</i></p>	\$0

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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><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</p>

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<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. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Our plan pays for the following while you get hospice services:</p> <ul style="list-style-type: none"> <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 B are billed to Medicare.</b></p> <ul style="list-style-type: none"> <li>• Refer to <b>Section F</b>, page 133 of this chapter for more information.</li> </ul> <p><b>For services covered by our plan but not covered by Medicare Part A or B:</b></p> <ul style="list-style-type: none"> <li>• Our plan covers services not covered under Medicare Part A or B. We cover the services whether or not they relate to your terminal prognosis. You pay 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>, Section F3, page 151 of your <i>Member Handbook</i>.</li> </ul> <p><b>Note:</b> If you need non-hospice care, call your care coordinator to arrange the services. Non-hospice care is care that is <b>not</b> related to your terminal prognosis.</p> <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>Hospice care (continued)</b></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><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	
<p> <b>Immunizations</b></p> <p>We pay for the following services:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B</li> <li>• COVID-19 vaccines</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>, Section D, page 160 of your <i>Member Handbook</i> to learn more.</p> <p>We also pay for all vaccines for adults as recommended by the Advisory Committee on Immunization Practices (ACIP).</p> <p><i>Some Part B drugs require prior authorization to be covered.</i></p>	\$0

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Services that our plan pays for	What you must pay
<p><b>In-home support services</b></p> <p>If you meet certain clinical criteria, we offer access to in-home support services, including cleaning, household chores and meal preparation as well as providing assistance with activities of daily living.</p> <p>Services must be recommended or requested by a licensed plan clinician or a licensed plan provider. You may participate in care management or be assessed by a care manager.</p> <p>Documentation of one of the following is required for services:</p> <ul style="list-style-type: none"> <li>• Alzheimer's/other dementia diagnosis</li> <li>• joint replacement surgery</li> <li>• fall recovery</li> <li>• limb amputation</li> <li>• cataract/retinal/other eye surgery</li> <li>• advanced cardio pulmonary disease</li> <li>• stroke</li> <li>• ambulation with assist device</li> <li>• impaired vision</li> <li>• frequent hospitalizations</li> <li>• frequent ER visits</li> <li>• post-surgery with chronic diseases, including one of the following: diabetes, COPD, congestive heart failure (CHF), urinary tract infection (UTI), renal disease, cancer, or behavioral health diagnosis.</li> </ul> <p>Services will be provided in 4-hour increments with a maximum of 12 visits per year. To find out more information call Member Services.</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> </ul> <p><b>This benefit is continued on the next page</b></p>	<p><b>\$0</b></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> <ul style="list-style-type: none"> <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. 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>You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is stabilized.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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 it is not reasonable and medically necessary.</p> <p>However, in certain situations where inpatient care is not covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services.</p> <p>We pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> <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. These are devices that replace all or part of: <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> </li> <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>\$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>, Section D4, page 54 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><i>You should talk to your provider and get a referral.</i></p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<div data-bbox="224 279 272 331"></div> <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>

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<p><b>Meals Benefit</b></p> <ul style="list-style-type: none"> <li>• <b>Post-Acute Meals:</b></li> </ul> <p>For members discharged from an inpatient facility (hospital, skilled nursing facility or inpatient rehabilitation) the plan will provide a maximum of 3 meals per day for 14-days for a total of 42 meals at no cost to you. You may choose to receive fresh frozen meals, shelf-stable meals, or a case of nutritional shakes. You may choose to receive a combination of meals and shakes within your total benefit limit, with a maximum of one case of shakes per instance.</p> <ul style="list-style-type: none"> <li>• <b>Chronic Meals:</b></li> </ul> <p>Members under care management with certain chronic conditions may be eligible to receive healthy meals as part of a supervised program to transition you to lifestyle modifications.</p> <ul style="list-style-type: none"> <li>○ Eligible chronic conditions include AIDS, asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure, coronary artery disease, diabetes, and hypertension.</li> <li>○ You may receive a maximum of 3 healthy meals per day for up to 28 days for a maximum of 84 meals per month. This benefit may be used for a maximum of 3 months per year.</li> <li>○ Subject to availability, you may choose to receive fresh frozen meals, shelf-stable meals, and/ or a case of nutritional shakes. You may choose to receive a combination of meals and shakes within your monthly limit, with a maximum of one case of shakes per month.</li> </ul> <p>Contact Member Services to schedule meal delivery. Phone numbers are located at the bottom of this page.</p> <p><i>You should talk to your provider and get a referral.</i></p>	<p>\$0</p>
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Services that our plan pays for	What you must pay
 <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 ordered by your doctor.</p> <p>We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary.</p> <p>We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.</p>	\$0
 <p><b>Medicare Diabetes Prevention Program (MDPP)</b></p> <p>Our plans pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> <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>	\$0

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Services that our plan pays for	What you must pay
<p><b>Medicare Part B prescription drugs</b></p> <p>These drugs are covered under Part B of Medicare. Some drugs may be subject to step therapy, which means you would have to try a different drug first to see if it works for you. 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>• Drugs you take using durable medical equipment (such as nebulizers) that our plan authorized</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <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>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> </ul> <p><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>• Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>• IV immune globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p>The following link takes you to a list of Part B drugs that may be subject to step therapy:  <a href="https://wellcare.healthnetcalifornia.com/step-therapy-part-b-drugs.html">https://wellcare.healthnetcalifornia.com/step-therapy-part-b-drugs.html</a>.</p> <p>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.</p> <p><b>Chapter 5</b>, Section A, page 138 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>, Section C2, page 159 of your <i>Member Handbook</i> explains what you pay for your outpatient prescription drugs through our plan.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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> <li>• Vision benefits</li> </ul> <p><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>• 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 home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care).</li> <li>• A nursing facility where your spouse or domestic partner is living at the time you leave the hospital.</li> </ul> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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>	\$0

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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 Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications</li> <li>• Substance use counseling</li> <li>• Individual and group therapy</li> <li>• Testing for drugs or chemicals in your body (toxicology testing)</li> </ul> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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 (includes complex tests such as CT, MRI, MRA, SPECT)</li> </ul> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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="http://www.medicare.gov/media/11101">www.medicare.gov/media/11101</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><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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 nurse practitioner</li> <li>• A physician assistant</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><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
<p><b>Outpatient substance abuse 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><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
<p><b>Outpatient surgery</b></p> <p>We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0

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Services that our plan pays for	What you must pay
<p><b>Over-the-counter (OTC) Items</b></p> <p>Our plan provides a benefit of \$ 260 every three months to spend on plan approved over-the-counter items through CVS.</p> <p>You have the flexibility of purchasing eligible OTC items from the catalog by phone, online, or at participating CVS retail locations with your plan's Member ID Card. You can place an order via the catalog online at <a href="http://www.cvs.com/otchs/healthnet">www.cvs.com/otchs/healthnet</a> or over the phone by calling 1-866-528-4679 (TTY: 711), and we'll deliver your items to your door at no additional cost to you.</p> <p>Please note, the OTC catalog may change every year. Be sure to review the current catalog to see what items are new and to identify any changes to items from last year. There is a limit of 3 mail orders per quarter. There is no order limit for in store purchases, up to allowance limit at participating locations. Additional limitations may apply to the quantity of certain items per quarter, noted in the catalog.</p> <p>Note: Under certain circumstances diagnostic equipment (such as equipment diagnosing blood pressure, cholesterol, diabetes, colorectal screenings, and HIV) and smoking-cessation aids are covered under the plan's medical benefits. To obtain the items and equipment listed above, you should (when possible) use our plan's other benefits rather than spending your OTC dollar allowance.</p>	\$0
<p><b>Partial hospitalization 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 or therapist's office. It can help keep you from having to stay in the hospital.</p> <p><b>Note:</b> Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0

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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> </ul> <p style="text-align: right;"><b>This benefit is continued on the next page</b></p>	<p>\$0</p>

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<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <li>• Certain telehealth services, including urgently needed services, home health services, primary care physician, occupational therapy, specialist, individual sessions for mental health, podiatry services, other health care professional, individual sessions for psychiatric, physical therapy and speech-language pathology services, individual sessions for outpatient substance abuse, and diabetes self-management training. <ul style="list-style-type: none"> <li>○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth.</li> </ul> </li> <li>• Our plan offers 24 hours per day, 7 days per week virtual visit access to board certified doctors via Teladoc to help address a wide variety of health concerns/questions. Covered services include general medical, behavioral health, dermatology, and more.</li> </ul> <p>A virtual visit (also known as a telehealth consult) is a visit with a doctor either over the phone or internet using a smart phone, tablet, or a computer. Certain types of visits may require internet and a camera-enabled device.</p> <p>For more information, or to schedule an appointment, call Teladoc at 1-800-835-2362 (TTY: 711) 24 hours a day, 7 days a week.</p> <ul style="list-style-type: none"> <li>• Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for patients in certain rural areas or other places approved by Medicare</li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p>
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	<p><b>Physician/provider services, including doctor's office visits (continued)</b></p> <ul style="list-style-type: none"> <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> <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> </ul> </li> </ul> <p><b>This benefit is continued on the next page</b></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>○ 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> <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> <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><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	

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Services that our plan pays for	What you must pay
<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>Additional routine foot care limited to 12 visits per year</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	\$0
<p> <b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, we pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> <li>• A digital rectal exam</li> <li>• A prostate specific antigen (PSA) test</li> </ul>	\$0

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Services that our plan pays for	What you must pay
<p><b>Prosthetic devices and related supplies</b></p> <p>Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> <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 devices. We also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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>We pay for respiratory services for ventilator-dependent patients.</p> <p><i>You should talk to your provider and get a referral.</i></p>	\$0
<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>	\$0

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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>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 home 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><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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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><i>You should talk to your provider and get a referral.</i></p>	<p>\$0</p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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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 Medi-Cal 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> </ul> <p><i>Depending on the service, prior authorization may be required.</i></p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p><b>Transportation services (additional routine)</b></p> <p>Our Medicare plan also covers a total of 48 one-way non-emergency ground transportation within our service area. This benefit is available to help you obtain medically necessary care and services.</p> <p>Trips are limited to: 75 miles, one-way, unless pre-approved by the plan. Call at least 72 hours in advance to schedule routine trips, or anytime for urgent trips. Certain locations may be excluded. For more information about plan-approved locations, please call Member Services.</p> <p>Please note: Medically necessary transportation services must be received from an in-network provider in order to be covered by the plan. Vehicles may transport multiple occupants at the same time and may stop at locations other than the member's destination during the trip. Be sure to reference any special needs or preferences when scheduling your ride.</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>For more information on how to obtain non-emergency medical transportation, please refer to Chapter 3, Section F2, page 59.</p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p><b>Urgent care</b></p> <p>Urgent 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>• A sudden medical 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 urgent care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider (for example, when you are outside the plan's service area or during the weekend).</p> <p>Urgently needed care received outside of the United States may be considered an emergency under the worldwide emergency/urgent coverage benefit. Refer to the emergency care benefit.</p>	<p>\$0</p>

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	<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</li> <li>• Up to \$100 for eyeglasses (frames and lenses) or up to \$100 for contact lenses every two years.</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 older</li> <li>• Hispanic Americans who are 65 or older</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>In addition, our plan covers the following supplemental (i.e., routine) vision services:</p> <ul style="list-style-type: none"> <li>• 1 routine eye exam every year. The routine eye exam includes a glaucoma test for people who are at risk for glaucoma and a retinal exam for diabetics.</li> <li>• Unlimited pairs of prescription eyewear every year up to a maximum benefit of \$400 every year. Covered eyewear includes any of the following: <ul style="list-style-type: none"> <li>○ Eyeglasses (frame and lenses) or</li> </ul> </li> </ul> <p><b>This benefit is continued on the next page</b></p>	<p>\$0</p>
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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).






Services that our plan pays for	What you must pay
<p><b>Vision care (continued)</b></p> <ul style="list-style-type: none"> <li>○ Eyeglass lenses only or</li> <li>○ Eyeglass frames only or</li> <li>○ Contact lenses instead of eyeglasses or</li> <li>○ Vision hardware upgrades</li> </ul> <p><b>Note:</b> Contact lenses fitting fee is covered by the plan.</p> <p>Maximum plan benefit coverage amount of \$400 every year applies to the retail cost of frames and/or lenses (including any lens options such as tints and coatings). You are responsible for any costs above the benefit maximum for supplemental (i.e., routine) eyewear.</p> <p>Medicare-covered eyewear is not included in the supplemental (i.e., routine) benefit maximum. Members cannot use their supplemental eyewear benefit to increase their coverage on Medicare-covered eyewear</p> <p><b>Note:</b> Coverage of routine vision services is a supplemental benefit offered by the plan. Neither Medicare nor Medicaid will pay your share of the costs for these services.</p> <p>Vision services must be obtained through the plan's vision network. For questions on how to find a provider or for more information call Member Services or visit us on our website at: <a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a>.</p> <p><i>You should talk to your provider and get a referral.</i></p> <p><i>Prior authorization (approval in advance) may be required to be covered, except in an emergency.</i></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. 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.

### E1. California Community Transitions (CCT)

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

You can get transition coordination services from any CCT Lead Organization that serves the county you live in. You can find a list of CCT Lead Organizations and the counties they serve on the Department of Health Care Services website at: [www.dhcs.ca.gov/services/ltc/Pages/CCT](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**, Section F, page 150 of your *Member Handbook*.

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

### E2. Medi-Cal Dental Program

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

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns

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- Root canal therapy
- Dentures, adjustments, repairs, and relines

Dental benefits are available in the Medi-Cal Dental Program as fee-for-service. For more information, or if you need help finding a dentist who accepts the Medi-Cal Dental Program, contact the Customer Service Line at 1-800-322-6384 (TTY users call 1-800-735-2922). The call is free. Medi-Cal Dental Services Program representatives are available to assist you from 8:00 a.m. to 5:00 p.m., Monday through Friday. You can also visit the website at [dental.dhcs.ca.gov/](http://dental.dhcs.ca.gov/) for more information.

In addition to the fee-for-service Medi-Cal Dental Program, you may get dental benefits through a dental managed care plan. Dental managed care plans are available in Los Angeles County. If you want more information about dental plans, need assistance identifying your dental plan, or want to change dental plans, contact Health Care Options at 1-800-430-4263 (TTY users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.

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

### E3. Hospice care

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

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

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

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

#### **For services covered by Medicare Part A or B that are not related to your terminal prognosis (except for emergency care or urgently needed care)**

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

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**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**, Section F3, page 151 of your *Member Handbook*.

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

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

This section tells you about benefits excluded by our plan. “Excluded” means that we do not pay for these benefits. Medicare and Medi-Cal do not 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**, Section E, page 198 of your *Member Handbook*.

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

- Services considered not “reasonable and medically necessary,” according to Medicare and Medi-Cal standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3**, Section I, page 64 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.

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- Personal items in your room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- 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 and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.

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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 or by mail-order. They include drugs covered under Medicare Part D and Medi-Cal. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4**, Section D, page 75 of your *Member Handbook*.

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

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

1. You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists or any similar Medicaid lists, State Medicaid Exclusion List and State Sanctioned or any similar State Medicaid lists.
3. You generally must use a network pharmacy to fill your prescription.
4. Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.
  - If it is not on the Drug List, we may be able to cover it by giving you an exception.
  - Refer to Chapter 9 to learn about asking for an exception.

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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.
5. Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration or supported by certain medical references. Your doctor may be able to help you identify medical references to support the requested use of the prescribed drug. For Medi-Cal covered drugs, this means the use of the drug is within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of disease, illness or injury.

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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 Member Services.

### A2. Using your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

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

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

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, state and federal law permit the pharmacy to issue no less than a 72-hour supply of your needed prescription in an emergency. Contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7**, Section A, page 162 of your *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services.

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

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

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

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

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



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

### A5. Using a specialized pharmacy

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

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

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

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

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. Drugs **not** available through our plan's mail-order service are marked with "NM" in our Drug List.

Our plan's mail-order service allows you to order up to a 90-day supply. A 90-day supply has the same copay as a one-month supply.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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## Filling prescriptions by mail

To get mail-order forms and information about filling your prescriptions by mail, visit our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA) or call Member Services (phone numbers are on the bottom of this page) for assistance.

Usually, a mail-order prescription arrives within 10-14 days. If your mail order is delayed, call Member Services (phone numbers are on the bottom of this page) for assistance.

## Mail-order processes

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

### 1. New prescriptions the pharmacy gets from you

The pharmacy automatically fills and delivers new prescriptions it gets from you.

### 2. New prescriptions the pharmacy gets from your provider's office

The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by contacting CVS Caremark at 1-866-808-7471 (TTY: 711).

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by calling CVS Caremark at 1-866-808-7471 (TTY: 711).

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling CVS Caremark at 1-866-808-7471 (TTY: 711).

### 3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling Member Services or your mail order pharmacy: CVS Caremark at 1-866-808-7471 (TTY: 711).

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. You should verify your contact information each time you place an order, at the time you enroll in the automatic refill program or if your contact information changes.

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

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90-day supply has the same copay as a one-month supply. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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

- You travel outside the plan's service area and need a drug that you can't get at a network pharmacy close to you.
- You need a drug urgently and there is no network pharmacy that is close to you and open.
- You must leave your home due to a federal disaster or other public health emergency.

Generally, we will cover a one-time fill up to a 30-day supply at an out-of-network pharmacy in these situations.

In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

### **A9. Paying you back for a prescription**

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

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**, Section A, page 162 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.

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

Our Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to “drugs” this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generic drugs and biosimilars work just as well as brand-name drugs or biological products and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

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

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

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

## B3. Drugs not on our Drug List

We don’t cover all prescription drugs. Some drugs are not on our Drug List because the law doesn’t allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List. If a drug was prescribed that is not on our Drug List, your prescription drug needs will always be evaluated under our plan’s coverage policies, as well as Medicare coverage rules.

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Our plan does not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9**, Section G5, page 220 of your *Member Handbook* for more information about appeals. For Part D excluded drugs that are coverable under Medi-Cal Rx, you may request a 14-day supply until your prior authorization can be reviewed and approved. Please contact Medi-Cal Rx Customer Service Center at 1-800-977-2273 for more information.

Here are three general rules for excluded drugs:

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

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

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Outpatient drugs made by a company that says you must have tests or services done only by them

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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.

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**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**, Section G4, page 218 of your *Member Handbook*.

### 1. Limiting use of a brand name drug when a generic version is available

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

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug or other covered drugs that treat the same condition will not work for you, then we cover the brand name drug.

### 2. Getting plan approval in advance

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

### 3. Trying a different drug first

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

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

### 4. Quantity limits

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

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA). If you disagree with our coverage or exception request

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



decision, you may request an appeal. For more information about this, refer to Section E, page 198 in Chapter 9.

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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 for the drug. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

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

### D1. Getting a temporary supply

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

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

1. The drug you've been taking:

- is no longer on our Drug List **or**
- was never on our Drug List **or**
- is now limited in some way

2. You must be in one of these situations:

- You were in our plan last year.
  - We cover a temporary supply of your drug **during the first 90 days of the calendar year.**

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p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- This temporary supply is for up to 30-days at a retail pharmacy and for up to 31-days at a long-term care pharmacy.
- If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication at a retail pharmacy and 31 days of medication at a long-term care pharmacy. You must fill the prescription at a network pharmacy.
- Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You are new to our plan.
  - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
  - This temporary supply is for up to 30 days at a retail pharmacy and for up to 31-days at a long-term care pharmacy.
  - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication at a retail pharmacy and 31 days of medication at a long-term care pharmacy. 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.
  - If your level of care changes, we will cover a temporary supply of your drugs. A level of care change happens when you are released from a hospital. It also happens when you move to or from a long-term care facility.
  - If you move home from a long-term care facility or hospital and need a temporary supply, we will cover one 30-day supply. If your prescription is written for fewer days, we will allow refills to provide up to a total of a 30-day supply.
  - If you move from home or a hospital to a long-term care facility and need a temporary supply, we will cover one 31-day supply. If your prescription is

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



written for fewer days, we will allow refills to provide up to a total of a 31-day supply.

- To ask for a temporary supply of a drug, call Member Services.

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

- Change to another drug.

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

#### OR

- Ask for an exception.

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

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9**, Section G4, page 218 of your *Member Handbook*.

If you need help asking for an exception, contact Member Services. If you disagree with our coverage or exception request decision, you may request an appeal (For more information about this, refer to section E, page 198 in Chapter 9.).

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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:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



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

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

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

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

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

Check our current Drug List online at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA) **or**

- Call Member Services at the number at the bottom of the page to check our current Drug List.

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

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug stays the same.

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

- We may not tell you before we make this change, but we send you information about the specific change we made once it happens.
- You or your provider can ask for an “exception” from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9**, Section G4, page 218 of your *Member Handbook* for more information on exceptions.

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p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- **A drug is taken off the market.** If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. You can talk to your doctor about other options.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

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

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

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9**, Section G4, page 218 of your *Member Handbook*.

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

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

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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

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leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

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

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

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

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

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

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

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

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4**, Section E3, page 130 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 drug that does the same thing

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

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

You may take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

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

Then, they will give you:

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

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





- Take your medication list with you if you go to the hospital or emergency room.

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

If you have questions about these programs, contact Member Services.

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

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

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

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

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter explains the limitations we think should apply.

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

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you a written decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization. To learn more about appeals and the Independent Review Organization, refer to **Chapter 9**, Section G6, page 222 of your *Member Handbook*.)

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



## 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 Member Services and ask for the “LIS Rider.”

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

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

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

- Our *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Most of the prescription drugs you get from a pharmacy are covered by our plan. Other drugs, such as some over-the-counter (OTC) medications and certain vitamins, may be covered by Medi-Cal Rx. Please visit the Medi-Cal Rx website ([medi-calrx.dhcs.ca.gov/](http://medi-calrx.dhcs.ca.gov/)) for more information. You can also call the Medi-Cal Rx Customer Service Center at 800-977-2273. Please bring your Medi-Cal Beneficiary Identification Card (BIC) when getting prescriptions through Medi-Cal Rx.
- **Chapter 5**, Section A, page 138 of your *Member Handbook*.
  - It tells how to get your outpatient prescription drugs through our plan.
  - It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5**, Section A, page 138 of your *Member Handbook* more information about network pharmacies.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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## A. The Explanation of Benefits (EOB)

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

- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Part D Explanation of Benefits*. This summary report is provided when you have had one or more prescriptions filled through the plan during the previous month. We call it the Part D EOB for short. The Part D EOB has more information about the drugs you take. The Part D EOB includes:

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

We offer coverage of drugs not covered under Medicare.

- 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 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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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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

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

### 1. Use your plan ID card.

Show your Wellcare by Health Net ID card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

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

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

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

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

For more information about asking us to pay you back for a drug, refer to **Chapter 7**, Section A, page 162 of your *Member Handbook*.

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

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

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

When you get a Part D EOB in the mail, make sure it is complete and correct. If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these Part D EOBs. They are an important record of your drug expenses.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules.

### C1. 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 90-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5**, Section A7, page 141 of your *Member Handbook* or our *Provider and Pharmacy Directory*.

### C2. What you pay

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 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 customer service center at 800-977-2273. Please bring your Medi-Cal beneficiary identification card (BIC) when getting prescriptions through Medi-Cal Rx.

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

	A network pharmacy	Our plan’s mail-order service	A network long-term care pharmacy	An out-of-network pharmacy
	A one-month or up to a 90-day supply	A one-month or up to a 90-day supply	Up to a 31-day supply	Up to a 30-day supply. Coverage is limited to certain cases. Refer to <b>Chapter 5</b> , Section A8, page 141 of your <i>Member Handbook</i> for details.
<b>Cost-sharing Tier 1</b> <b>(All Part D Drugs)</b>	\$0	\$0	\$0	\$0

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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

---

## D. Vaccinations

**Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Member Services for more information.

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.

### D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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## Chapter 7: Asking us to pay a bill you got 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 Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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## A. Asking us to pay for your services or drugs

You should not get a bill from in-network services or drugs. Our network providers must bill the health plan for your covered services and drugs after you get them. A network provider works with the health plan. **If you get a bill for 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 the bill, it is your right to be paid back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services if you have any questions. If you get a bill and you don't know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

### 1. When you get emergency or urgently needed health care from an out-of-network provider. Refer to Chapter 3, Section D4, page 54.

Ask the provider to bill us.

- If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
- You may get a bill from the provider asking for payment that you think you don't owe. Send us the bill and proof of any payment you made.
  - If the provider should be paid, we will pay the provider directly.
  - If you already paid for the service, we will pay you back.
- Refer to **Chapter 5** Section A8, page 141 of your *Member Handbook* to learn more about out-of-network pharmacies.

### 2. When a network provider sends you a bill

Network providers must always bill us. Show your plan ID card when you get any services or prescriptions. Improper or inappropriate billing occurs when a provider

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(such as a doctor or hospital) bills you more than our cost sharing amount for services. **Call Member Services if you get any bills. Do not pay the bill.**

- Because we pay the entire cost for your covered services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, 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, send us the bill and proof of any payment you made. We will pay you back for your covered services.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5**, Section A8, page 141 of your *Member Handbook* to learn more about out-of-network pharmacies.

### 4. When you pay the full prescription cost because you don't have your plan ID card with you

If you don't have your plan ID card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your plan ID card.
- Send us a copy of your receipt when you ask us to pay you back.

### 5. When you pay the full prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
  - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9**, Section G4, page 218 of your *Member Handbook*).

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- If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to **Chapter 9**, Section G4, page 218 of your *Member Handbook*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9**, Section G5, page 220 of your *Member Handbook*.

---

## B. Sending us a request for payment

Send us your bill and proof of any payment you made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It’s a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help.

To make sure you give us all the information we need to make a decision, 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.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)), or you can call Member Services and ask for the form.

Mail your request for payment together with any bills or receipts to this address. Please provide an approved type of proof of payment, which can be a copy of a canceled check, a credit or debit card statement or a receipt of a wire transfer:

Medical Claims address:

**Wellcare by Health Net**  
Attn: Member Reimbursement Dept  
P.O. Box 9030  
Farmington, MO 63640

**You must submit your claim to us within one calendar year** from the date you got the service or item.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



Pharmacy Claims address:

**Wellcare by Health Net**

Attn: Member Reimbursement Dept

P.O. Box 31577

Tampa, FL 33631-3577

**You must submit your claim to us within three years** from the date you got the drug.

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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 let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we pay the provider directly.

**Chapter 3**, Section B, page 46 of your *Member Handbook* explains the rules for getting your services covered. **Chapter 5**, Section A, page 138 of your *Member Handbook* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 Section E, page 198.

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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**, Section E2, page 198. of your *Member Handbook*:

- To make an appeal about getting paid back for a health care service, refer to **Chapter 9**, Section E, page 198.
- To make an appeal about getting paid back for a drug, refer to **Chapter 9**, Section G5, page 220.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## 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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## A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services at 1-800-431-9007 (TTY: 711) or write to:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net wants to make sure you understand your health plan information. We can send materials to you in another language or alternate format if you ask for it this way. This is called a “standing request.” We will document your choice. Please call us if:

- You want to get your materials in Arabic, Armenian, Cambodian (Khmer), Chinese (traditional characters), Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese or in an alternate format. You can ask for one of these languages in an alternate format.
- You want to change the language or format that we send you materials.

If you need help understanding your plan materials, please contact Wellcare by Health Net Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

**If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:**

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.
- Medi-Cal Office of Civil Rights at 916-440-7370. TTY users should call 711.

### لديك الحق في الحصول على الخدمات والمعلومات بالطريقة التي نفي باحتياجاتك

يجب أن نضمن تقديم كل الخدمات لك بطريقة تتسم بالكفاءة الثقافية وسهولة الوصول. ويتوجب علينا أيضًا إخبارك عن مزايا الخطة التي نقدمها وحقوقك بطريقة يمكنك فهمها. ولا بد لنا أن نخبرك بحقوقك سنويًا طالما أنك تشترك معنا في خطتنا.

- للحصول على المعلومات بطريقة تتمكن من فهمها، اتصل بخدمات الأعضاء. تتضمن خطتنا خدمات ترجمة فورية مجانية متاحة للإجابة على الأسئلة بلغات مختلفة.
- بمقدور خطتنا تزويدك أيضًا بمواد بلغات أخرى غير اللغة الإنجليزية وبتنسيقات مختلفة مثل الطباعة بأحرف كبيرة أو طريقة برايل أو التسجيل الصوتي. للحصول على المواد بأحد هذه التنسيقات البديلة، يرجى الاتصال بخدمات الأعضاء على الرقم 1-800-431-9007 (الهاتف النصي TTY: 711) أو إرسال خطاب إلى:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

ترغب Wellcare by Health Net في التأكد من أنك تفهم معلومات خطتك الصحية. يمكننا أن نرسل إليك مواد بلغة أخرى أو بتنسيق بديل إذا طلبت ذلك. يُطلق على ذلك اسم "الطلب القائم". وسنقوم بتوثيق اختيارك. الرجاء الاتصال بنا في حالة:

- كنت تريد الحصول على المواد باللغة العربية أو الأرمنية أو الكمبودية (الخميرية) أو الصينية (بأحرف تقليدية) أو الفارسية أو الكورية أو الروسية أو الإسبانية أو التاجالوجية أو الفيتنامية أو بتنسيق بديل. يمكنك طلب إحدى هذه اللغات بتنسيق بديل.
- كنت تريد تغيير اللغة أو التنسيق الذي نرسل به المواد إليك.

إذا كنت بحاجة إلى مساعدة لفهم مواد خطتك، فيرجى الاتصال بخدمات أعضاء Wellcare by Health Net على الرقم 1-800-431-9007 (الهاتف النصي TTY: 711). في الفترة ما بين 1 أكتوبر و31 مارس، يكون الممثلون متاحون من الإثنين إلى الأحد، من الساعة 8 صباحًا إلى الساعة 8 مساءً. وفي الفترة ما بين 1 أبريل و30 سبتمبر، يكون الممثلون متاحون من الإثنين إلى الجمعة، من الساعة 8 صباحًا إلى الساعة 8 مساءً.

إذا كنت تواجه صعوبة في الحصول على معلومات من خطتنا نتيجة لمشاكل تخص اللغة أو الإعاقة وتريد تقديم شكوى، فاتصل بـ:

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- Ցանկանում եք փոխել լեզուն կամ ձևաչափը, որով մենք ձեզ նյութեր ենք ուղարկում:

Եթե ծրագրի նյութերը հասկանալու հարցում օգնության կարիք ունեք, ապա խնդրում ենք դիմել Wellcare by Health Net-ի Անդամների ծառայությունների կենտրոն՝ 1-800-431-9007 հեռախոսահամարով (TTY՝ 711): Հոկտեմբերի 1-ից մարտի 31-ն ընկած ժամանակահատվածում ներկայացուցիչները հասանելի են երկուշաբթիից կիրակի, ժամը՝ 8 a.m. - 8 p.m.: Ապրիլի 1-ից սեպտեմբերի 30-ն ընկած ժամանակահատվածում ներկայացուցիչները հասանելի են երկուշաբթիից ուրբաթ օրերին, ժամը՝ 8 a.m. - 8 p.m.:

Եթե մեր ծրագրից տեղեկություն ստանալու դժվարություններ ունեք լեզվի խնդիրների կամ հաշմանդամության պատճառով և ցանկանում եք զանազատ ներկայացնել, ապա զանգահարեք

- Medicare-ին՝ 1-800-MEDICARE (1-800-633-4227) հեռախոսահամարով: Կարող եք զանգահարել օրը 24 ժամ, շաբաթը 7 օր: TTY օգտագործողները պետք է զանգահարեն 1-877-486-2048 հեռախոսահամարով:
- ԱՄ Առողջության և մարդու ծառայությունների բաժանմունքի Քաղաքացիական իրավունքների գրասենյակ՝ 1-800-368-1019 հեռախոսահամարով: TTY օգտվողները պետք է զանգահարեն 1-800-537-7697 հեռախոսահամարով:
- Medi-Cal Քաղաքացիական իրավունքների գրասենյակ՝ 916-440-7370: TTY օգտագործողները պետք է զանգահարեն՝ 711:

**សិទ្ធិរបស់អ្នកដើម្បីទទួលបានសេវាកម្ម**

**និងព័ត៌មានតាមរបៀបដែលបំពេញតម្រូវការរបស់អ្នក**

យើងត្រូវធ្វើឱ្យប្រាកដថាសេវាកម្ម **ទាំងអស់**នឹងត្រូវបានផ្តល់ជូនដល់អ្នកតាមរបៀបដែល អាចចូលប្រើបាន និងសមស្របតាមវប្បធម៌។ យើងក៏ត្រូវតែប្រាប់អ្នកអំពីអត្ថប្រយោជន៍ នានានៃកម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកតាមរបៀបដែលអ្នកអាចយល់បាន។ យើងត្រូវតែ ប្រាប់អ្នកអំពីសិទ្ធិនានារបស់អ្នកជារៀងរាល់ឆ្នាំ ដែលអ្នកស្ថិតនៅក្នុងកម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មានតាមរបៀបដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅកាន់សេវាបម្រើសមាជិក។ គម្រោងរបស់យើងមានអ្នកបកប្រែផ្ទាល់មាត់ដោយឥតគិតថ្លៃ ដែលអ្នកអាចរកបានដើម្បីឆ្លើយសំណួរនានាជាភាសាផ្សេងៗ។
- គម្រោងរបស់យើងខ្ញុំក៏ផ្តល់ជូនអ្នកនូវឯកសារ ជាភាសាផ្សេងទៀតក្រៅពីភាសាអង់គ្លេសផងដែរ នៅក្នុងទម្រង់ដូចជាអក្សរពុម្ពធំៗ អក្សរសម្រាប់ជនពិការភ្នែក ឬជាសំឡេង។ ដើម្បីទទួលបានឯកសារក្នុងទម្រង់ជំនួយ

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8

p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



ណាមួយក្នុងចំណោមទម្រង់ទាំងនេះ សូមទូរសព្ទទៅកាន់សេវាសមាជិកតាមលេខ 1-800-431-9007 (TTY: 711) ឬសរសេរទៅកាន់៖

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net ចង់ធ្វើឱ្យប្រាកដថា អ្នកយល់អំពីព័ត៌មានគម្រោងសុខភាពរបស់អ្នក។

យើងអាចបញ្ជូនព័ត៌មានទៅកាន់អ្នកជាភាសាមួយទៀតឬជាទម្រង់ផ្សេងទៀត បើសិនអ្នកស្នើសុំវាបែបនេះ។ នេះត្រូវបានគេហៅថា "សំណើអចិន្ត្រៃយ៍"។ យើងនឹងចងក្រងឯកសារជម្រើសរបស់អ្នក។ សូមហៅទូរសព្ទមកពួកយើង បើសិន៖

- អ្នកចង់ទទួលបានព័ត៌មានរបស់អ្នកជាភាសាអារ៉ាប់ អាមេនី កម្ពុជា (ខ្មែរ) ចិន (អក្សរចិនបុរាណ) ហ្វារស៊ី កូរ៉េ រុស្ស៊ី អេស្ប៉ាញ តាហ្គាឡ វៀតណាម ឬ ជាទម្រង់ផ្សេង។  
អ្នកអាចស្នើសុំភាសាណាមួយក្នុងចំណោមភាសាទាំងនេះជាទម្រង់ផ្សេងបាន។
- អ្នកចង់ផ្លាស់ប្តូរភាសា ឬទម្រង់នៃព័ត៌មាន ដែលយើងផ្ញើទៅកាន់អ្នក។

ប្រសិនបើអ្នកត្រូវការជំនួយក្នុងការស្វែងយល់អំពីឯកសាររបស់គម្រោងរបស់អ្នក សូមទាក់ទងផ្នែកសេវាបម្រើសមាជិករបស់ Wellcare by Health Net តាមរយៈលេខ 1-800-431-9007 (TTY: 711)។ ចន្លោះពីថ្ងៃទី 1 ខែតុលា និងថ្ងៃទី 31 ខែមីនា អ្នកតំណាងអាចរកបានពីថ្ងៃចន្ទ ដល់ ថ្ងៃអាទិត្យ ពីម៉ោង 8 ព្រឹក ដល់ ម៉ោង 8 យប់។ ចន្លោះពីថ្ងៃទី 1 ខែមេសា និងថ្ងៃទី 30 ខែកញ្ញា អ្នកតំណាងអាចរកបានពីថ្ងៃចន្ទដល់ថ្ងៃសុក្រ ពីម៉ោង 8 ព្រឹក ដល់ ម៉ោង 8 យប់។

**ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើងខ្ញុំព្រោះតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់បណ្តឹងតវ៉ា នោះសូមទូរសព្ទទៅកាន់៖**

- Medicare តាមរយៈលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកអាចហៅទូរសព្ទ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ ។ អ្នកប្រើ TTY គួរតែទូរសព្ទទៅលេខ 1-877-486-2048។
- ការិយាល័យសម្រាប់សិទ្ធិស៊ីវិលរបស់ក្រសួងសេវាសុខាភិបាល និងមនុស្ស តាមរយៈលេខ 1-800-368-1019 ។ អ្នកប្រើ TTY គួរហៅទៅកាន់លេខ 1-800-537-7697 ។
- ការិយាល័យសម្រាប់សិទ្ធិស៊ីវិលរបស់ Medi-Cal តាមលេខ 916-440-7370។ អ្នកប្រើប្រាស់ TTY គួរទូរសព្ទទៅកាន់លេខ 711។

**If you have questions,** please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information,** visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



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## 您有權以符合您需求的方式取得服務和資訊

我們必須確保**所有**服務均以文化適合且可以取得的方式提供給您。我們也必須透過您能夠瞭解的方式告知您有關我們計劃的福利及您的權利。只要您尚在本計劃中，我們每年皆必須告知您有關您的權利。

- 如欲透過您能夠瞭解的方式取得資訊，請致電會員服務部。本項計劃有免費口譯服務，能以不同語言回答問題。
- 本計畫也可以為您提供英語以外的語言版本、大字版、點字版或語音版的資訊。若要取得以上替代格式的材料，請致電會員服務部：1-800-431-9007 (TTY: 711) 或寫信至：

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net 希望確保您瞭解自己的健保計劃資訊。如果您提出要求，我們可以用其他語言或其他格式向您傳送材料。這被稱為「長期申請」。我們將會記錄您的選擇。如果您有以下要求，請致電我們：

- 您需要阿拉伯語、亞美尼亞語、柬埔寨語 (高棉語)、中文 (繁體字)、波斯語、韓語、俄語、西班牙語、塔加洛語、越南語或其他格式的材料。您可以要求用另一種格式提供其中一種語言。
- 您想變更我們向您傳送材料的語言或格式。

如果您需要幫助來瞭解自己的計劃材料，請致電聯絡 Wellcare by Health Net 會員服務部，電話是 1-800-431-9007 (聽障專線：711)。在 10 月 1 日至 3 月 31 日期間，代表的服務時間為週一至週日，早上 8 點至晚上 8 點。在 4 月 1 日至 9 月 30 日期間，代表的服務時間為週一至週五，早上 8 點至晚上 8 點。

如果您因語言問題或身心障礙，而在向本計劃取得資訊時遭遇困難，因而想要提出投訴，請致電：

- Medicare，電話是：1-800-MEDICARE (1-800-633-4227)。您可以全天候撥打，每天 24 小時，每週 7 天均提供服務。聽障專線使用者請致電 1-877-486-2048。
- U.S. Department of Health and Human Services, Office for Civil Rights，電話是：1-800-368-1019。聽障專線使用者請致電 1-800-537-7697。
- Medi-Cal Office of Civil Rights 電話是：916-440-7370。聽障專線使用者請撥打 711。

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



### شما حق دارید خدمات و اطلاعات را به صورتی دریافت کنید که نیازهای شما را برآورده کند

ما باید اطمینان حاصل کنیم که همه خدمات به شیوه‌ی فرهنگی مناسب و قابل دسترس به شما ارائه می‌شود. همچنین ما باید مزایای برنامه درمانی و حقوق قانونی شما را به صورتی به شما بگوئیم که برایتان قابل فهم باشد. ما باید هر سال حقوق قانونی که در برنامه ما دارید را به شما بگوئیم.

- برای دریافت اطلاعات به شکلی که برایتان قابل فهم باشد، با مرکز خدمات تماس بگیرید. طرح ما دارای خدمات مترجم رایگان برای پاسخ به سؤالات به زبان‌های مختلف است.
- برنامه ما همچنین می‌تواند مطالبی به همه زبان‌های غیر از انگلیسی و فرمت‌هایی مثل چاپ درشت، خط بریل و فرمت صوتی برای شما فراهم کند. برای دریافت مطالب در یکی از این قالب‌های جایگزین، لطفاً با خدمات اعضا به شماره 1-800-431-9007 (TTY: 711) تماس بگیرید یا با آدرس زیر مکاتبه کنید:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net می‌خواهد مطمئن شود که اطلاعات برنامه سلامت خود را درک کرده‌اید. در صورت درخواست شما، می‌توانیم مطالب را به زبان‌ها یا قالب‌های دیگر برای شما ارسال کنیم. این کار «درخواست دائمی» نامیده می‌شود. ما انتخاب شما را ثبت می‌کنیم. لطفاً در موارد زیر با ما تماس بگیرید:

- تمایل دارید مطالب را به زبان‌های عربی، ارمنی، کامبوجی (خمر)، چینی (نویسه‌های سنتی)، فارسی، کره‌ای، روسی، اسپانیایی، تاگالوگ، ویتنامی یا در قالب دیگر دریافت کنید. می‌توانید یکی از این زبان‌ها را در قالب جایگزین درخواست کنید.
- تمایل دارید زبان یا قالب مطالب ارسالی‌مان به شما را تغییر دهید.

چنانچه برای درک مطالب برنامه خود نیاز به کمک دارید، لطفاً با مرکز خدمات اعضای به این شماره تماس بگیرید 1-800-431-9007 (TTY: 711) تماس بگیرید. بین 1 اکتبر و 31 مارس، نمایندگان از دوشنبه تا یکشنبه، 8 صبح تا 8 بعدازظهر در دسترس هستند. بین 1 آوریل و 30 سپتامبر، نمایندگان از دوشنبه تا جمعه، 8 صبح تا 8 بعدازظهر در دسترس هستند.

اگر به خاطر مشکلات زبانی یا معلولیت، در دریافت اطلاعات از برنامه درمانی ما با مشکل مواجه هستید و می‌خواهید شکایتی را اقامه کنید، با این شماره‌ها تماس بگیرید:

- Medicare به شماره 1-800-MEDICARE (1-800-633-4227). می‌توانید در 24 ساعت شبانه‌روز و 7 روز هفته تماس بگیرید. کاربران TTY باید با شماره 1-877-486-2048 تماس بگیرند.
- با اداره بهداشت و خدمات انسانی ایالات متحده، دفتر حقوق مدنی به شماره 1-800-368-1019 تماس بگیرید. کاربران TTY باید با شماره 1-800-537-7697 تماس بگیرند.
- دفتر حقوق مدنی Medi-Cal به شماره 916-440-7370. کاربران TTY باید با 711 تماس بگیرند.

If you have questions, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. For more information, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





## 귀하의 필요에 부합되는 방식으로 서비스와 정보를 받아볼 권리

모든 서비스가 문화적으로 유능하고 접근 가능한 방식으로 귀하에게 제공될 수 있도록 해야 합니다. 당사는 또한 당사 플랜의 혜택, 귀하의 권리를 반드시 귀하가 이해할 수 있는 방식으로 귀하에게 알려 드려야 합니다. 또한 귀하께서 당사의 보험 플랜에 계속해 가입해 있는 한 매년 반드시 귀하의 권리를 공지해 드려야 합니다.

- 귀하가 이해하실 수 있는 방법으로 정보를 얻으시려면 가입자 서비스부에 문의해 주십시오. 당사 플랜은 다양한 언어로 질문에 답변하기 위해 무료 통역 서비스를 제공합니다.
- 당사 플랜은 영어 이외의 다른 언어와 대형 인쇄체, 점자 또는 오디오 형식으로 된 자료도 제공해 드릴 수 있습니다. 이러한 대체 형식 중 하나로 자료를 구하려면 가입자 서비스부에 1-800-431-9007(TTY: 711)번으로 문의하시거나 다음 주소로 편지를 보내 주십시오.

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Clayton, MO 63105

Wellcare by Health Net는 귀하가 자신의 건강 플랜 정보를 확실히 이해하실 수 있도록 도울 것입니다. 귀하의 요청이 있을 경우, 다른 언어로 작성되었거나 대체 형식으로 제작된 자료를 보내드릴 수 있습니다. 이를 “지속 요청”이라 합니다. 귀하가 선택하신 방식으로 문서를 준비하여 발송해 드립니다. 아래와 같은 경우라면 문의해 주십시오.

- 아랍어, 아르메니아어, 캄보디아어(크메르어), 중국어(번체), 이란어, 한국어, 러시아어, 스페인어, 타갈로그어, 베트남어 등의 언어로 된 자료나 다른 형태로 된 자료를 받고 싶으실 수 있습니다. 이들 언어 중 한 가지를 선택하여 대체 형식 자료를 요청하실 수 있습니다.
- 당사가 가입자에게 보내드리는 자료의 언어나 형식을 바꾸고 싶으실 수도 있습니다.

귀하의 플랜 자료를 이해하는 데 있어 도움이 필요하시면, Wellcare by Health Net 가입자 서비스부에 1-800-431-9007(TTY: 711)번으로 연락해 주십시오. 10월 1일부터 3월 31일까지는 상담원과 월요일~일요일, 오전 8시~오후 8시에 통화하실 수 있습니다. 4월 1일부터 9월 30일까지는 월요일~금요일, 오전 8시~오후 8시에 통화하실 수 있습니다.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8

p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



당사 플랜에 대한 정보를 얻는 데 있어 언어나 장애 문제로 어려움이 있고 이에 대해 불만을 제기하기 원하시면,

- Medicare에 1-800-MEDICARE(1-800-633-4227)로 문의해 주십시오. 주 7일 24시간 언제든지 문의하실 수 있습니다. TTY 사용자는 1-877-486-2048번으로 문의하시면 됩니다.
- 미국 보건 복지부(Department of Health and Human Services) 인권 사무국(Office for Civil Rights)에 1-800-368-1019번으로 문의해 주십시오. TTY 사용자는 1-800-537-7697번으로 문의해 주십시오.
- Medi-Cal 인권 사무국(Office of Civil Rights)에 916-440-7370번으로 문의해 주십시오. TTY 사용자는 711번으로 문의해 주십시오.

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### Ваше право на получение услуг и информации в соответствии с вашими потребностями

Мы должны обеспечить, чтобы **все** услуги предоставлялись вам доступным образом и с учетом культурных особенностей. Мы также должны сообщать вам об объеме покрываемых услуг в рамках плана и ваших правах в понятной для вас форме. Пока вы остаетесь участником нашего плана, мы должны каждый год сообщать вам о ваших правах.

- Для того чтобы получить информацию в удобной для вас форме, позвоните в наш отдел обслуживания участников плана. Наш план предоставляет бесплатные услуги переводчика, который поможет ответить на ваши вопросы на необходимом вам языке.
- Наш план также может предоставить вам материалы на языках, отличных от английского, и в таких форматах, как крупный шрифт, шрифт Брайля или аудиозапись. Чтобы получить материалы в одном из этих альтернативных форматов, позвоните в отдел обслуживания участников плана по номеру 1-800-431-9007 (TTY: 711) либо напишите по адресу:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Мы хотим, чтобы вы понимали всю информацию, связанную с вашим планом страхования Wellcare by Health Net. По вашему запросу мы можем присылать вам материалы на другом языке или в другом формате. Такой запрос называется «постоянно действующим запросом». Мы внесем ваш выбор в свою документацию. Позвоните нам, если:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





- Вы хотите получать материалы на арабском, армянском, камбоджийском (кхмерском), китайском (традиционном), корейском, русском, испанском, тагальском, вьетнамском языках, на фарси или же в другом формате. Вы можете запросить материалы на одном из этих языков в другом формате.
- Вы хотите изменить язык или формат материалов, которые мы вам присылаем.

Если вам нужна помощь с пониманием информации, представленной в материалах о плане страхования, обратитесь в отдел обслуживания участников плана Wellcare by Health Net по номеру 1-800-431-9007 (TTY: 711). С 1 октября по 31 марта наши представители доступны с понедельника по воскресенье с 8 а.м. до 8 р.м. С 1 апреля по 30 сентября с нашими представителями можно связаться с понедельника по пятницу с 8 а.м. до 8 р.м.

**Если у вас возникли трудности при получении информации от сотрудников нашего плана из-за языкового барьера или ограниченных возможностей и вы хотите подать жалобу, позвоните в:**

- Medicare по номеру 1-800-MEDICARE (1-800-633-4227). Эта линия работает круглосуточно и без выходных. При использовании TTY набирайте 1-877-486-2048.
- Управление по гражданским правам (Office for Civil Rights) при Департаменте здравоохранения и социальных служб США (U.S. Department of Health and Human Services) по номеру 1-800-368-1019. При использовании TTY набирайте 1-800-537-7697.
- Управление по гражданским правам (Office of Civil Rights) Medi-Cal по номеру 916-440-7370. При использовании TTY набирайте 711.

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### **Su derecho a obtener información y servicios de manera tal que satisfaga sus necesidades**

Debemos garantizar que **todos** los servicios se le proporcionen de una manera accesible y culturalmente competente. Además, debemos explicarle los beneficios de nuestro plan y sus derechos de una manera que usted pueda comprender. Debemos explicarle sus derechos cada año que tenga la cobertura de nuestro plan.

- Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios al Afiliado. Nuestro plan ofrece servicios de interpretación gratuitos para responder preguntas en diferentes idiomas.
- El plan también puede proporcionarle material en otros idiomas, además del inglés, y en distintos formatos como en braille, en audio o en letra grande. Para

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



obtener materiales en uno de estos formatos alternativos, llame al Departamento de Servicios para Miembros al 1-800-431-9007 (TTY: 711) o escriba a la siguiente dirección:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net quiere asegurarse de que comprende la información de su plan de salud. Podemos enviarle materiales en otros idiomas o en formatos alternativos si así los solicita. Esto se denomina “solicitud permanente”.

Guardaremos su elección. Llámenos en los siguientes casos:

- Si quiere recibir sus materiales en árabe, armenio, camboyano (jemer), chino (caracteres tradicionales), farsi, coreano, ruso, español, tagalo o vietnamita, o en un formato alternativo. También puede solicitar que se le envíen en uno de estos idiomas y, a su vez, en un formato alternativo.
- Si quiere cambiar el idioma o el formato en el que le enviamos los materiales.

Si necesita ayuda para entender los materiales de su plan, comuníquese con el Departamento de Servicios para Miembros de Wellcare by Health Net al 1-800-431-9007 (TTY: 711). Entre el 1 de octubre y el 31 de marzo, los representantes están disponibles de lunes a domingo, de 8 a.m. a 8 p.m. Entre el 1 de abril y el 30 de septiembre, los representantes están disponibles de lunes a viernes, de 8 a.m. a 8 p.m.

**Si tiene dificultades para obtener información de nuestro plan por problemas relacionados con el idioma o una discapacidad y quiere presentar una queja, comuníquese con:**

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



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### Ang inyong karapatang makakuha ng mga serbisyo at impormasyon sa isang paraan na tumutugon sa mga pangangailangan ninyo

Dapat naming tiyakin na an **lahat** ng serbisyo ay ibinibigay sa inyo sa paraang naaangkop at naa-access ayon sa kultura. Dapat din naming sabihin sa inyo ang tungkol sa mga benepisyo ng aming plano at ang inyong mga karapatan sa paraang mauunawaan ninyo. Dapat naming sabihin sa inyo ang tungkol sa inyong mga karapatan bawat taon na nasa plano namin kayo.

- Para makakuha ng impormasyon sa isang paraan na maiintindihan ninyo, tawagan ang Mga Serbisyo para sa Miyembro. Ang aming plano ay may libreng serbisyo sa interpretasyon na handang sumagot sa mga tanong sa iba't ibang wika.
- Mabibigyan rin kayo ng aming plano ng mga materyales na nasa mga wika maliban sa Ingles at nasa mga format tulad ng malalaking letra, braille, o audio. Para makakuha ng mga materyal sa isa sa mga alternatibong format na ito, tumawag sa Mga Serbisyo sa Miyembro sa 1-800-431-9007 (TTY: 711) o sumulat sa:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Gustong matiyak ng Wellcare by Health Net na nauunawaan ninyo ang impormasyon ng inyong planong pangkalusugan. Maaari kaming magpadala sa inyo ng mga materyal sa ibang wika o alternatibong format kung hihilingin ninyo ito sa ganitong paraan. Tinatawag itong “pangmatagalang kahilingan.” Itatala namin ang inyong pinili. Pakitawagan kami kung:

- Gusto ninyong makuha ang inyong mga materyal sa Arabic, Armenian, Cambodian (Khmer), Chinese (mga tradisyonal na karakter), Farsi, Korean, Russian, Spanish, Tagalog, Vietnamese o sa isang alternatibong format. Maaari ninyong hilingin ang isa sa mga wikang ito sa isang alternatibong format.
- Gusto ninyong baguhin ang wika o format na ipinadala namin sa inyo sa mga materyal.

Kung kailangan ninyo ng tulong sa pag-unawa sa mga materyal ng inyong plano, makipag-ugnayan sa Mga Serbisyo para sa Miyembro ng Wellcare by Health Net sa 1-800-431-9007 (TTY: 711). Mula Oktubre 1 hanggang Marso 31, available ang mga kinatawan Lunes–Linggo, 8 a.m. hanggang 8 p.m. Mula Abril 1 hanggang Setyembre 30, available ang mga kinatawan Lunes–Biyernes, 8 a.m. hanggang 8 p.m.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



**Kung nahihirapan kayong makakakuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at gusto ninyong maghain ng reklamo, tawagan ang:**

- Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kayong tumawag 24 na oras sa isang araw, 7 araw sa isang linggo. Dapat tumawag ang mga gumagamit ng TTY sa 1-877-486-2048.
- Tanggapan para sa mga Karapatang Sibil ng Kagawaran ng mga Serbisyong Pangkalusugan at Pantao ng U.S. sa 1-800-368-1019. Dapat tumawag ang mga gumagamit ng TTY sa 1-800-537-7697.
- Tanggapan para sa mga Karapatang Sibil ng Medi-Cal sa 916-440-7370. Ang mga gumagamit ng TTY ay dapat tumawag sa 711.

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**Quý vị có quyền nhận các dịch vụ và thông tin theo cách đáp ứng nhu cầu của quý vị**

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

- Để nhận thông tin theo cách thức quý vị có thể hiểu được, hãy gọi cho bộ phận Dịch vụ thành viên. Chương trình của chúng tôi có các dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi bằng các ngôn ngữ khác nhau.
- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị các tài liệu bằng ngôn ngữ khác không phải tiếng Anh và bằng các định dạng chẳng hạn như bản in cỡ lớn, chữ nổi braille hoặc âm thanh. Để nhận các tài liệu ở một trong các định dạng thay thế này, vui lòng gọi cho Bộ Phận Dịch Vụ Thành Viên theo số 1-800-431-9007 (TTY: 711) hoặc viết thư cho:

Wellcare by Health Net  
7700 Forsyth Boulevard  
Clayton, MO 63105

Wellcare by Health Net muốn đảm bảo quý vị hiểu được thông tin trong chương trình sức khỏe của mình. Chúng tôi có thể gửi cho quý vị các tài liệu bằng ngôn ngữ khác hoặc bằng định dạng thay thế nếu quý vị có yêu cầu. Điều này được gọi là “yêu cầu thường xuyên”. Chúng tôi sẽ ghi chép lại lựa chọn của quý vị. Vui lòng gọi cho chúng tôi nếu:

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- Quý vị muốn nhận tài liệu bằng tiếng Ả Rập, tiếng Armenia, tiếng Campuchia (tiếng Khmer), tiếng Trung (phồn thể), tiếng Farsi, tiếng Hàn, tiếng Nga, tiếng Tây Ban Nha, tiếng Tagalog, tiếng Việt hoặc bằng định dạng thay thế. Quý vị có thể yêu cầu một trong những ngôn ngữ này ở định dạng thay thế.
- Quý vị muốn thay đổi ngôn ngữ hoặc định dạng của tài liệu mà chúng tôi gửi cho quý vị.

Nếu quý vị cần trợ giúp để hiểu rõ các tài liệu của chương trình, vui lòng liên lạc với Bộ Phận Dịch Vụ Thành Viên của Wellcare by Health Net theo số 1-800-431-9007 (TTY: 711). Từ ngày 1 tháng 10 đến 31 tháng 3, nhân viên đại diện sẽ làm việc từ Thứ Hai - Chủ Nhật, từ 8 giờ sáng đến 8 giờ tối. Từ ngày 1 tháng 4 đến 30 tháng 9, nhân viên đại diện sẽ làm việc từ Thứ Hai - Thứ Sáu, từ 8 giờ sáng đến 8 giờ tối.

**Nếu quý vị gặp khó khăn với việc tiếp nhận thông tin từ chương trình của chúng tôi do các vấn đề về ngôn ngữ hoặc do khuyết tật và quý vị muốn nộp đơn khiếu nại, hãy gọi:**

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

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## **B. Our responsibility for your timely access to covered services and drugs**

If you cannot get a timely appointment to receive covered services and your doctor does not think you can wait longer for the appointment, you can call Wellcare by Health Net's Member Services Department at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. and they can assist you. If you cannot get services within a reasonable amount of time, we have to pay for out of network care.

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3**, Section D, page 49 of your *Member Handbook*.

- Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- Women have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - This includes the right to get timely service from specialists.
  - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3**, Section D4, page 54 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**, Section F, page 12 of your *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

**Chapter 9**, Section E, page 198 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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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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

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

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights to your information and to control how your PHI is used. We give you a written notice that tells you about these rights and explains how we protect the privacy of your PHI. The notice is called the “Notice of Privacy Practice.”

Members who may consent to receive sensitive services are not required to obtain any other member’s authorization to receive sensitive services or to submit a claim for sensitive services. A member can either start a confidential communication request in writing to the health plan or by electronic transmission. A confidential communications request shall be implemented by the health insurer within seven 7 calendar days of the receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt in writing by first-class mail. Wellcare by Health Net 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. Wellcare by Health Net will not disclose medical information related to sensitive services to any other member without written authorization from the member receiving care. Wellcare by Health Net 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.

### C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don’t give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don’t need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan’s quality of care.
- We must release PHI by court order.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws. If we share your information with Medi-Cal, it will also be done according to federal and state laws.

## **C2. Your right to look at your medical records**

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we shared your PHI with others.

If you have questions or concerns about the privacy of your PHI, call Member Services.

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## **D. Our responsibility to give you information**

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call us at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. This is a free service to you. We can also give you information in large print, braille, or audio. You can also get this handbook in the following languages for free:

- Arabic
- Armenian
- Cambodian
- Chinese
- Farsi
- Korean
- Russian

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)





- Spanish
- Tagalog
- Vietnamese

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

- How to choose or change plans
- Our plan, including:
  - financial information
  - how plan members have rated us
  - the number of appeals made by members
  - how to leave our plan
- Our network providers and our network pharmacies, including:
  - how to choose or change primary care providers
  - qualifications of our network providers and pharmacies
  - how we pay providers in our network
- Covered services and drugs and about rules you must follow, including:
  - services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
  - limits to your coverage and drugs
  - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9**, Section D, page 197 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

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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**, Section A, page 162 of your *Member Handbook*.

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## F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage plan.
  - You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another Medicare Advantage plan.
  - Refer to **Chapter 10**, Section C, page 247 of your *Member Handbook*:
    - For more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
    - For information about how you will get your Medi-Cal benefits if you leave our plan.
- 

## G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

### G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about different treatment options.
  - **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- 

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9**, Section E, page 198 of your *Member Handbook* tells how to ask us for a coverage decision.

## G2. Your right to say what you want to happen

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

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.
- **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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
  - The hospital will ask if you have a signed advance directive form and if you have it with you.
  - If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.
- Learn about changes to advance directive laws. Wellcare by Health Net will tell you about changes to the state law no later than 90 days after the change.

Having an advance directive is **your** choice. Call Member Services for more information.

### **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 your local Office for Civil Rights.

Office for Civil Rights  
U.S. Department of Health & Human Services  
90 7th Street, Suite 4-100  
San Francisco, CA 94103

You can call the Office for Civil Rights at 1-800-368-1019 (TTY: 1-800-537-7697).

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

**Chapter 9**, Section D, page 197 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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

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

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

- Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
- The Health Insurance Counseling and Advocacy Program (HICAP) program at 1-213-383-4519 (TTY: 711). For more details about HICAP, refer to **Chapter 2**, Section E, page 29.
- The Ombuds Program at 1-888-452-8609. For more details about this program, refer to **Chapter 2**, Section I, page 33 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).)

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## I. Your responsibilities as a plan member

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

- **Read the *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
  - Covered services, refer to **Chapters 3 and 4** of your *Member Handbook*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, refer to **Chapters 5 and 6** of your *Member Handbook*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your plan ID card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care 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 with other providers.
- **Tell us about any services you receive outside of our plan.**
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For most plan members, Medi-Cal pays for your Part A premium and your Part B premium.
  - **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
  - **If you move outside of our service area you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1**, Section D, page 11 of your *Member Handbook* tells you about our service area.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



- We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
- Tell Medicare and Medi-Cal your new address when you move. Refer to **Chapter 2**, Section G, page 31 of your *Member Handbook* for phone numbers for Medicare and Medi-Cal.
- **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Tell us if you have a new phone number** or a better way to contact you.
- Call Member Services for help if you have questions or concerns.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)



## 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 Ombuds Program at 1-888-452-8609 for help.**

This chapter explains different options you have for different problems and complaints, but you can always call the Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to **Chapter 2**, Section I, page 33 of your *Member Handbook*.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8

p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





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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” instead of “Independent Review Entity”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

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## 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## Help from the Health Consumer Alliance

You can call the Health Consumer Alliance and speak with an advocate about your health coverage questions. They offer free legal help. The Health Consumer Alliance is not connected with us or with any insurance company or health plan. Their phone number is 1-888-804-3536 and their website is [www.healthconsumer.org](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

The State Medi-Cal Managed Care “Ombudsman Office” can help you with any questions. You may call them at 1-888-452-8609 (TTY: 711), Monday through Friday, 8am to 5pm PST; excluding holidays. You can also get help from your doctor or call us at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free.

The Ombuds Program is not connected with us or with any insurance company or health plan. They can help you understand which process to use. The services are free.

## 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.

## Help from the California Department of Managed Health Care

Contact the California Department of Managed Health Care for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Wellcare by Health Net is a health care service plan.)

If you have a grievance against Wellcare by Health Net, you should first telephone Wellcare by Health Net at **1-800-431-9007 (TTY: 711)** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Wellcare by Health Net, or a grievance that has remained unresolved for more than 30 days, then you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department's internet website <http://www.dmhca.ca.gov> has complaint forms, IMR application forms and instructions online.

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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 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**, page 207 explains these situations.

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## D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The chart below helps you find the right section of this chapter for problems or complaints.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



<b>Is your problem or concern about your benefits or coverage?</b>  This includes problems about whether particular medical care or prescription drugs are covered or not, the way they are covered, and problems about payment for medical care or prescription drugs.	
<p style="text-align: center;"><b>Yes.</b></p> <p style="text-align: center;">My problem is about benefits or coverage.</p> <p>Refer to <b>Section E</b>, page 198, “Coverage decisions and appeals.”</p>	<p style="text-align: center;"><b>No.</b></p> <p style="text-align: center;">My problem is not about benefits or coverage.</p> <p>Refer to <b>Section K</b>, page 239, “How to make a complaint.”</p>

## E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

### E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or drugs. We make a coverage decision whenever we decide what is covered for you and how much we pay. For example, your network doctor makes a favorable coverage decision for you whenever you get medical care from them or if they refer you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or Medi-Cal. If you disagree with this coverage decision, you can make an appeal.

### E2. Appeals

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

In most cases, you must start your appeal at Level 1. If you do not want to first appeal to the plan for a Medi-Cal service, if your health problem is urgent or involves an immediate and serious threat to your health, or if you are in severe pain and need an immediate decision, you may ask for an Independent Medical Review from the Department of Managed Health Care at [www.dmhca.ca.gov](http://www.dmhca.ca.gov). Refer to page 199 for more information.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, page 202, you can ask for an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **No** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. An Independent Review Organization that is not connected to us conducts the Level 2 Appeal.

- In some situations, your case is **automatically sent** to the Independent Review Organization for a Level 2 Appeal. If this happens, we tell you.
- In other situations, you **need to ask** for a Level 2 Appeal.
- Refer to **Section F4**, page 207 for more information about Level 2 Appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

### E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- **Health Insurance Counseling and Advocacy Program (HICAP)** at 1-800-434-0222.
- **The Help Center at the Department of Managed Health Care (DMHC)** for free help. The DMHC is responsible for regulating health plans. The DMHC helps people with appeals about Medi-Cal services or billing problems. The phone number is 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TDD number, 1-877-688-9891.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
  - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.
  - Ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the “Appointment of Representative” form. You can also get the form by visiting [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf) or on our website at <https://wellcare.healthnetcalifornia.com/member-resources/member-rights/appointing-a-representative.html>. **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 Member Services at the numbers at the bottom of the page.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





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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 your care.

This section is about your benefits for medical care and services that are described in **Chapter 4**, Section D, page 75 of your *Member Handbook*. We generally refer to “medical care coverage” or “medical care” in the rest of this section. The term “medical care” includes medical services and items as well as Medicare Part B prescription drugs which are usually drugs administered by your doctor or health care professional. Different rules may apply to a Part B prescription drug. When they do, we explain how rules for Part B prescription drugs differ from rules for medical services and items.

### F1. Using this section

This section explains what you can do in any of the following situations:

1. You think we cover medical care you need but are not getting.

**What you can do:** You can ask us to make a coverage decision. Refer to **Section F2**, page 202.

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**, page 204.

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**, page 213.

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**, page 213.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

6. You are experiencing delays in care or you cannot find a doctor.

**What you can do:** You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**, page 207.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- If the coverage is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Refer to **Section H**, page 224 or **Section I**, page 231 to find out more.
- For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

## F2. Asking for a coverage decision

When a coverage decision involves your medical care, it's called an **"integrated organization determination."**

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free.
- Faxing: 1-844-273-2671.
- Writing: Wellcare by Health Net  
4191 E. Commerce Way  
Sacramento, CA 95834.

### 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 5 working days of when Wellcare by Health Net gets the information needed to make a decision, and no later than 14 calendar days after Wellcare by Health Net receives the request.
- Medicare Part B prescription drug within 72 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



If you think we should **not** take extra days, you can make a “fast complaint” about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to **Section K**, page 239.

### Fast coverage decision

The legal term for “fast coverage decision” is “**expedited determination**.”

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a “fast coverage decision.” A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

**For a medical item or service, we can take up to 14 more calendar days** if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can’t take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a “fast complaint” about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**, page 239. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can’t ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

**We automatically give you a fast coverage decision if your doctor tells us your health requires it.** If you ask without your doctor’s support, we decide if you get a fast coverage decision.

If we decide that your health doesn’t meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- 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**, page 239.

**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**, page 204).

In limited circumstances we may dismiss your request for a coverage decision, which means we won’t review the request. Examples of when a request will be dismissed include:

- If the request is incomplete,
- If someone makes the request on your behalf but isn’t legally authorized to do so, or
- If you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

### **F3. Making a Level 1 Appeal**

**To start an appeal**, you, your doctor, or your representative must contact us. Call us at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

**Ask for a standard appeal or a fast appeal** in writing or by calling us at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- 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://wellcare.healthnetcalifornia.com/member-resources/member-rights/appointing-a-representative.html>.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.

You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

### **If your health requires it, ask for a fast appeal.**

The legal term for “fast appeal” is “**expedited reconsideration.**”

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.
- The process for a fast appeal is the same as for a fast coverage decision. To ask for a fast appeal, follow the instructions for asking for a fast coverage decision in **Section F2**, page 202.
- If your doctor tells us that your health requires it, we will give you a fast appeal.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.**

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal **within 10 calendar days** of the date on our letter or by the intended effective date of the action, whichever is later.
  - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
  - You will also get all other services or items (that are not the subject of your appeal) with no changes.
  - If you do not appeal before these dates, then your service or medication will not be continued while you wait for your appeal decision.

**We consider your appeal and give you our answer.**

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

**There are deadlines for a fast appeal.**

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.

If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, Section F4, page 207, we tell you about this organization and explain the Level 2 appeals process.

- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- **If we say No to part or all of your request**, we send your appeal to the Independent Review Organization for a Level 2 Appeal.

**There are deadlines for a standard appeal.**

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.

If we don't give you an answer by the deadline, we must send your request to Level 2 of the appeals process. An Independent Review Organization then reviews it. Later in this chapter, section F4, page 208, we tell you about this organization and explain the Level 2 appeals process.

**If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say No to part or all of your request, **you have additional appeal rights:**

If we say **No** to part or all of what you asked for, we send you a letter.

- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the Independent Review Organization for a Level 2 Appeal.
- If your problem is about coverage of a Medi-Cal service or item, the letter tells you how to file a Level 2 Appeal yourself.

#### **F4. Making a Level 2 Appeal**

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, Medi-Cal, or both programs usually cover the service or item.

- If 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, page 208. We do not automatically file a Level 2 Appeal for you for Medi-Cal services or items.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- If your problem is about a service or item that **both Medicare and Medi-Cal** may cover, you automatically get a Level 2 Appeal with the Independent Review Organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F4**, page 207 for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the Independent Review Organization.
- If your problem is about a service that usually covered only by Medi-Cal, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

### When your problem is about a service or item Medicare usually covers

The Independent Review Organization reviews your appeal. It's an independent organization hired by Medicare.

The formal name for the "Independent Review Organization" is the "**Independent Review Entity**," sometimes called the "**IRE**."

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the Independent Review Organization, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization take a careful look at all information related to your appeal.

### If you had a fast appeal at Level 1, you also have a fast appeal at Level 2.

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The Independent Review Organization must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





**If you had a standard appeal at Level 1, you also have a standard appeal at Level 2.**

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the Independent Review Organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.

The Independent Review Organization gives you their answer in writing and explains the reasons.

- **If the Independent Review Organization says Yes to part or all of a request for a medical item or service**, we must promptly implement the decision:
  - Authorize the medical care coverage **within 72 hours** or
  - Provide the service within **14 calendar days** after we get the Independent Review Organization's decision for **standard requests** or
  - Provide the service **within 72 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- If the Independent Review Organization says **Yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:
  - **Within 72 hours** after we get the Independent Review Organization's decision for **standard requests** or
  - **Within 24 hours** from the date we get the Independent Review Organization's decision for **expedited requests**.
- If the Independent Review Organization 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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 or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J**, page 236 for more information about Level 3, 4, and 5 Appeals.

### **When your problem is about a service or item Medi-Cal usually covers**

There are two ways to make a Level 2 appeal for Medi-Cal services and items: (1) Filing a complaint or Independent Medical Review or (2) State Hearing.

#### **(1) Independent Medical Review**

You can file a complaint with or ask for an Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.

**NOTE:** If your provider filed an appeal for you, but we do not get your Appointment of Representative form, you will need to refile your appeal with us before you can file for a Level 2 IMR with the Department of Managed Health Care.

You are entitled to both an IMR and a State Hearing, but not if you have already had a State Hearing on the same issue.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



In most cases, you must file an appeal with us before requesting an IMR. Refer to page 208 for information, about our Level 1 appeal process. If you disagree with our decision, you can file a complaint with the DMHC or ask the DMHC Help Center for an IMR.

If your treatment was denied because it was experimental or investigational, you do not have to take part in our appeal process before you apply for an IMR.

If your problem is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may bring it immediately to the DMHC's attention without first going through our appeal process.

You must **apply for an IMR within 6 months** after we send you a written decision about your appeal. The DMHC may accept your application after 6 months for good reason, such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice from us of the IMR process.

To ask for an IMR:

- Fill out the Independent Medical Review Application/Complaint Form available at: [www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx](http://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx) or call the DMHC Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- If you have them, attach copies of letters or other documents about the service or item that we denied. This can speed up the IMR process. Send copies of documents, not originals. The Help Center cannot return any documents.
- Fill out the Authorized Assistant Form if someone is helping you with your IMR. You can get the form at [www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx](http://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx) or call the Department's Help Center at 1-888-466-2219. TTY users should call 1-877-688-9891.
- Mail or fax your forms and any attachments to:

Help Center  
Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
FAX: 916-255-5241

If you qualify for an IMR, the DMHC will review your case and send you a letter within 7 calendar days telling you that you qualify for an IMR. After your application and supporting

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



documents are received from your plan, the IMR decision will be made within 30 calendar days. You should receive the IMR decision within 45 calendar days of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within 2 calendar days telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within 3 calendar days. You should receive the IMR decision within 7 calendar days of the submission of the completed application. If you are not satisfied with the result of the IMR, you can still ask for a State Hearing.

An IMR can take longer if the DMHC does not receive all of the medical records needed from you or your treating doctor. If you are using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

## **(2) State Hearing**

You can ask for a State Hearing for Medi-Cal covered services and items. If your doctor or other provider asks for a service or item that we will not approve, or we will not continue to pay for a service or item you already have and we said no to your Level 1 appeal, you have the right to ask for a State Hearing.

In most cases **you have 120 days to ask for a State Hearing** after the "Your Hearing Rights" notice is mailed to you.

**NOTE:** If you ask for a State Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to submit your request** if you want to keep getting that service while your State Hearing is pending. Read "Will my benefits continue during Level 2 appeals" on page 207 for more information.

There are two ways to ask for a State Hearing:

1. You may complete the "Request for State Hearing" on the back of the notice of action. You should provide all requested information such as your full name, address, telephone number, the name of the plan or county that took the action against you, the aid program(s) involved, and a detailed reason why you want a hearing. Then you may submit your request one of these ways:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- To the county welfare department at the address shown on the notice.
  - To the California Department of Social Services:  
  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, California 94244-2430
  - To the State Hearings Division at fax number 916-651-5210 or 916-651-2789.
2. You can call the California Department of Social Services at 1-800-952-5253. TTY users should call 1-800-952-8349. If you decide to ask for a State Hearing by phone, you should be aware that the phone lines are very busy.

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

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **Independent Review Organization**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An Administrative Law Judge or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the Independent Review Organization explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J**, page 236 for more information about your appeal rights after Level 2.

## F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. **You are never required to pay the balance of any bill.**

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund if you followed the rules for getting services or item.

For more information, refer to **Chapter 7** of your *Member Handbook*. It describes situations when you may need to ask us to pay your back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send your provider the payment for the service or item within 60 calendar days after we get your request. 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**, page 204. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the Independent Review Organization. We will send you a letter if this happens.

- If the Independent Review Organization reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- If the Independent Review Organization says **No** to your appeal, it means they agree that we should not approve your request. This is called “upholding the decision” or “turning down your appeal.” You will get a letter explaining additional appeal rights you may have. Refer to **Section J**, page 236 for more information about additional levels of appeal.

If our answer to your appeal is **No** and **Medi-Cal** usually covers the service or item, you can file a Level 2 Appeal yourself. We do not automatically file a level 2 appeal for you. Refer to **Section F4**, page 207 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 Part D drug appeals.** We'll say “drug” in the rest of this section. Instead of saying “Part D drug” every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5**, Section B3, page 143 of your *Member Handbook* for more information about a medically accepted indication.

### G1. Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including asking us to:
  - Cover a Part D drug that is not on our plan's Drug List or
  - Set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

**NOTE:** If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Part D drugs is called a “**coverage determination**.”

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
<b>You can ask us to make an exception.</b> (This is a type of coverage decision.)	<b>You can ask us for a coverage decision.</b>	<b>You can ask us to pay you back.</b> (This is a type of coverage decision.)	<b>You can make an appeal.</b> (This means you ask us to reconsider.)
Start with <b>Section G2</b> , page 216, then refer to <b>Sections G3</b> , page 217 and <b>G4</b> , page 218.	Refer to <b>Section G4</b> , page 218.	Refer to <b>Section G4</b> , page 218.	Refer to <b>Section G5</b> , page 220.

## G2. Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

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."**

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





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

- 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**, Section C, page 144 of your *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called "prior authorization."
  - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called "step therapy."
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

## 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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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**, page 220 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 1-800-431-9007 (TTY: 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information about the claim. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.
- 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**, page 199 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**, Section A, page 162 of your *Member Handbook*.
- If you ask for an exception, give us a “supporting statement.” The supporting statement includes your doctor or other prescriber’s medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

#### **If your health requires it, ask us for a “fast coverage decision.”**

We use the “standard deadlines” unless we agree to use the “fast deadlines.”

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor’s statement.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



A “fast coverage decision” is called an “**expedited coverage determination.**”

You can get a fast coverage decision if:

- It’s for a drug you didn’t get. You can’t get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn’t meet the requirements for a fast coverage decision, we use the standard deadlines instead.

We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.

You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**, page 239.

### **Deadlines for a fast coverage decision**

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor’s supporting statement. We give you our answer sooner if your health requires it.
- If we don’t meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization. Refer to **Section G6**, page 222 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**

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

#### **Deadlines for a standard coverage decision about a drug you already bought**

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an Independent Review Organization.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

### **G5. Making a Level 1 Appeal**

An appeal to our plan about a Part D drug coverage decision is called a plan **"redetermination."**

- Start your **standard** or **fast appeal** by calling 1-800-431-9007 (TTY: 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Include your name, contact information, and information regarding your claim.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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**, page 218 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.

**Deadlines for a fast appeal at Level 1**

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
- We give you our answer sooner if your health requires it.

If we don’t give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6**, page 222 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**Deadlines for a standard appeal at Level 1**

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.

If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6**, page 222 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.

If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an Independent Review Organization reviews it. Refer to **Section G6**, page 222 for information about the review organization and the Level 2 appeals process.

- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

**G6. Making a Level 2 Appeal**

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **Independent Review Organization** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



The formal name for the “Independent Review Organization” is the “**Independent Review Entity**,” sometimes called the “**IRE**.”

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the Independent Review Organization **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you include **instructions about how to make a Level 2 Appeal** with the Independent Review Organization. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the Independent Review Organization, we send the information we have about your appeal to the organization. This information is called your “case file.” **You have the right to a free copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

The Independent Review Organization reviews your Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4**, page 207 for more information about the Independent Review Organization.

### **Deadlines for a fast appeal at Level 2**

If your health requires it, ask the Independent Review Organization for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the Independent Review Organization’s decision.

### **Deadlines for a standard appeal at Level 2**

If you have a standard appeal at Level 2, the Independent Review Organization must give you an answer:

- **Within 7 calendar days** after they get your appeal for a drug you didn’t get.
- **Within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the Independent Review Organization says **Yes** to part or all of your request:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- We must provide the approved drug coverage **within 72 hours** after we get the Independent Review Organization's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the Independent Review Organization's decision.

If the Independent Review Organization says **No** to your appeal, it means they agree with our decision not to approve your request. This is called “upholding the decision” or “turning down your appeal.”

If the Independent Review Organization says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The Independent Review Organization sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the Independent Review Organization says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
  - Decide if you want to make a Level 3 Appeal.
  - Refer to the letter the Independent Review Organization sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, page 236 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**, Section D, page 75 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you’re being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

## H1. Learning about your Medicare rights

Within two days after you’re admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called “**An Important Message from Medicare about Your Rights.**” Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don’t get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 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.
  - 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800 MEDICARE (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 reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The Quality Improvement Organization is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In California, the Quality Improvement Organization is Livanta. Call them at 1-877-588-1123 (TTY: 1-855-887-6668). Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**, Section F, page 29.

**Call the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date.**

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the Quality Improvement Organization’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, appeal to our plan directly instead. Refer to **Section G4**, page 218 for information about making an appeal to us.
- Because hospital stays are covered by both Medicare and Medi-Cal, if the Quality Improvement Organization will not hear your request to continue your hospital stay, or you believe that your situation is urgent, involves an immediate and serious threat to your health, or you are in severe pain, you may also file a complaint with or ask the California Department of Managed Health Care

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



(DMHC) for an Independent Medical Review. Please refer to Section F4 on page 207 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

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

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

**Ask for a fast review.** Act quickly and contact the Quality Improvement Organization to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review.**”

### What happens during fast review

- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue after the planned discharge date. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you will get another notice that explains why your doctor, the hospital, and we think that is the right discharge date that’s medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) You can also refer to a sample notice online at [www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices](http://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices).

Within one full day after getting all of the information it needs, the Quality Improvement Organization give you their answer to your appeal.

If the Quality Improvement Organizations says **Yes** to your appeal:

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Improvement Organization says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you their answer to your appeal.
- You can make a Level 2 Appeal if the Quality Improvement Organization turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

### H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123 (TTY: 1-855-887-6668).

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Quality Review Organization says **Yes** to your appeal:

- We must pay you back for our share of hospital care costs since noon on the day after the date the Quality Improvement Organization turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Quality Review Organization says **No** to your appeal:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section E4 on page 200 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, page 236 for information about Level 3, 4, and 5 Appeals.

#### H4. Making a Level 1 Alternate Appeal

The deadline for contacting the Quality Improvement Organization for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

The legal term for "fast review" or "fast appeal" is "**expedited appeal.**"

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

### H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of giving saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K**, page 239 for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, page 236 for information about Level 3, 4, and 5 Appeals.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please refer to Section F4 on page 207 to learn how to file a

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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.

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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
- Rehabilitation care as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

### I1. Advance notice before your coverage ends

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

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

### I2. Making a Level 1 Appeal

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

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K**, page 239 for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
  - Call Member Services at the numbers at the bottom of the page.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- Call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222.
- **Contact the Quality Improvement Organization.**
  - Refer to **Section H2**, page 226 or refer to **Chapter 2**, Section F, page 29 of your *Member Handbook* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a “fast-track appeal.** Ask the Quality Improvement Organization if it's medically appropriate for us to end coverage of your medical services.

### Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage we sent you.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**, page 234.
- If the Quality Improvement Organization will not hear your request to continue coverage of your health care services or you believe that your situation is urgent or involves an immediate and serious threat to your health or if you are in severe pain, you may file a complaint with and ask the California Department of Managed Health Care (DMHC) for an Independent Medical Review. Please refer to Section F4 on page 207 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

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

### What happens during a fast-track appeal

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





- Reviewers at the Quality Improvement Organization ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is “**Detailed Explanation of Non-Coverage.**”

- Reviewers tell you their decision within one full day after getting all the information they need.

If the Independent Review Organization says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

### **I3. Making a Level 2 Appeal**

For a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your Level 1 Appeal. Call them at 1-877-588-1123 (TTY: 1-855-887-6668).

You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



Quality Improvement Organization reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the Independent Review Organization says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 on page 207 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, page 236 for information about Level 3, 4, and 5 Appeals.

#### **I4. Making a Level 1 Alternate Appeal**

As explained in **Section I2**, page 231, you must act quickly and contact the Quality Improvement Organization to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review.”

The legal term for “fast review” or “fast appeal” is “**expedited appeal**.”

- We look at all of the information about your case.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.
- We agree to pay you back for our share of the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- Our coverage for these services ends on the date we told you.
- We will not pay any share of the costs after this date.
- You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
- We send your appeal to the Independent Review Organization to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

## 15. Making a Level 2 Alternate Appeal

During the Level 2 Appeal,

We send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K**, page 239 for information about making complaints.

The Independent Review Organization does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the Independent Review Organization says **Yes** to your appeal:

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the Independent Review Organization says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to Section F4 on page 207 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

An Administrative Law Judge or attorney adjudicator handles Level 3 Appeals. Refer to **Section J**, page 236 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 Independent Review Organization for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

#### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

### Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

### Level 5 Appeal

A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## J2. Additional Medi-Cal appeals

You also have other appeal rights if your appeal is about services or items that Medi-Cal usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

## J3. Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

### Level 3 Appeal

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

### Level 4 Appeal

The Medicare Appeals Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- 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.

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## 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>

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



Complaint	Example
<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, Member Services, 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>
<b>Information you get from us</b>	<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>
<b>Timeliness related to coverage decisions or appeals</b>	<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 Independent Review Organization 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

**If you have questions,** please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information,** visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





help making an internal and/or external complaint, you can call Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m.

The legal term for a “complaint” is a **“grievance.”**

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

## K2. Internal complaints

To make an internal complaint, call Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- If you ask for a written response, we will respond in writing. If you file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing.
- We will send you a letter within 5 calendar days of receiving your complaint letting you know that we received it.

We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. In certain cases, you have the right to ask for a fast review of your complaint. This is called the “fast complaint” procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:

- We deny your request for a fast review of a request for medical care or Medicare Part D drugs.
- We deny your request for a fast review of an appeal of denied services or Medicare Part D drugs.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denied medical care.
- Complaints related to Medicare Part D must be made within 60 calendar days after you had the problem you want to complain about. All other types of complaints must be filed with us or the provider within anytime from the day the incident or action occurred that caused you to be dissatisfied.

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.

**The legal term for “fast complaint” is “expedited grievance.”**

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call.

- We answer most complaints within 30 calendar days.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

### **K3. External complaints**

#### **Medicare**

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx).

You do not need to file a complaint with Wellcare by Health Net before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



If you have any other feedback or concerns, or if you feel the health plan not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

## Medi-Cal

**You can file a complaint with the California Department of Health Care Services (DHCS) Medi-Cal Managed Care Ombudsman by calling 1-888-452-8609. TTY users can call 711. Call Monday through Friday between 8:00 a.m. and 5:00 p.m.**

You can file a complaint with the California Department of Managed Health Care (DMHC). The DMHC is responsible for regulating health plans. You can call the DMHC Help Center for help with complaints about Medi-Cal services. You may contact the DMHC if you need help with a complaint involving an urgent issue or one that involves an immediate and serious threat to your health, if you are in severe pain, if you disagree with our plan's decision about your complaint, or if our plan has not resolved your complaint after 30 calendar days.

Here are two ways to get help from the Help Center:

- Call 1-888-466-2219. Individuals who are deaf, hard of hearing, or speech-impaired can use the toll-free TTY number, 1-877-688-9891. The call is free.
- Visit the Department of Managed Health Care's website ([www.dmhca.ca.gov](http://www.dmhca.ca.gov)).

## Office for Civil Rights

You can make a complaint to the Department of Health and Human Services Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit [www.hhs.gov/ocr](http://www.hhs.gov/ocr) for more information.

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

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: 1-800-368-1019
TTY: 1-800-537-7697
Fax: 1-202-619-3818

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



You may also have rights under the Americans with Disability Act and under the Unruh Civil Rights Act. You can contact the Ombuds Program for assistance. The phone number is 1-888-452-8609 (TTY: 711), Monday through Friday, 8am to 5pm PST; excluding holidays.

### Quality Improvement Organization

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the Quality Improvement Organization.
- You can make your complaint to the Quality Improvement Organization and to our plan. If you make a complaint to the Quality Improvement Organization, we work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the Quality Improvement Organization, refer to **Section H2**, page 226 or refer to **Chapter 2** of your *Member Handbook*.

In California, the Quality Improvement Organization is called Livanta. Their phone number is 1-877-588-1123 (TTY: 1-855-887-6668).

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



## 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 Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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## A. When you can end your membership with our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Medi-Cal, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- You moved out of our service area,
- Your eligibility for Medi-Cal or Extra Help changed, **or**
- If you recently moved into, currently are getting care in, or just moved out of a nursing home or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1** page 248.
- Medi-Cal services in **Section C2** page 250.

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

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Member Services at the numbers at the bottom of the page.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- California Health Insurance Counseling and Advocacy Program (HICAP), at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit [www.aging.ca.gov/HICAP/](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, you may not be able to change plans. Refer to **Chapter 5**, Section G3, page 153 of your *Member Handbook* for information about drug management programs.

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## B. How to end your membership in our plan

You have the following options if you want to leave our plan:

- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 248.
- Call Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 a.m. to 6:00 p.m. TTY users should call 1-800-430-7077.
- Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

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## C. How to get Medicare and Medi-Cal services

You have choices about getting your Medicare and Medi-Cal services if you choose to leave our plan.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**C1. Your Medicare services**

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

<p><b>1. You can change to:</b></p> <p><b>Another Medicare health plan</b> including a plan that combines your Medicare and Medi-Cal coverage</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 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. 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. Your Medi-Cal plan may change.</p>
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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





<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. 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> <p>Your Medi-Cal plan will not change.</p>
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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



<p><b>3. You can change to:</b></p> <p><b>Original Medicare without a separate Medicare prescription drug plan</b></p> <p><b>NOTE:</b> If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.</p> <p>You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit <a href="http://www.aging.ca.gov/HICAP/">www.aging.ca.gov/HICAP/</a>.</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. 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>You are automatically disenrolled from our plan when your Original Medicare coverage begins.</p> <p>Your Medi-Cal plan will not 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.

## D. How to get your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Wellcare by Health Net ends, our plan will cover your hospital stay until 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 Part B coverage.
- If you no longer qualify for Medi-Cal. Our plan is only for people who qualify for both Medicare and Medi-Cal. The state of California or Medicare will disenroll you from the Wellcare by Health Net plan and you will return to Original Medicare. If you are receiving Extra Help to pay for your Medicare Part D prescription drugs, CMS will auto-enroll you into a Medicare Prescription Drug Plan. If you later qualify again for Medi-Cal and wish to re-enroll in Wellcare by Health Net, you will need to call 1-800-431-9007, Monday through Friday from 8:00 a.m. to 5:00 p.m. TTY users should call 711. Tell them you want to re-join Wellcare by Health Net.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services notify us if you're not eligible to remain a member on this basis.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



- We must disenroll you if you don't meet this requirement.

The plan's period of deemed continued eligibility is six months. The period of deemed continued eligibility begins the first of the month following the month in which you lose special needs status.

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

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your plan ID card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

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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**, Section K, page 239 of your *Member Handbook* for information about how to make a complaint.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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## 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 Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m.

to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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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

Every company or agency that works with Medicare and Medi-Cal must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit [www.hhs.gov/ocr](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).
- Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov).
- Fill out a complaint form or send a letter to:

Deputy Director, Office of Civil Rights  
Department of Health Care Services  
Office of Civil Rights  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413  
Complaint forms are available at:

[www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)

If you believe that you have been discriminated against and want to file a discrimination grievance, contact Member Services at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day. You can also contact us in writing at:

Wellcare by Health Net  
Appeals & Grievances  
Medicare Operations  
P.O. Box 10450  
Van Nuys, CA 91410-0450  
[www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)

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 [dhcs.ca.gov/Pages/Language\\_Access.aspx](http://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 Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services 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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



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.

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## D. Independent contractors

The relationship between Wellcare by Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Wellcare by Health Net and neither Wellcare by Health Net, nor any employee of Wellcare by Health Net, is an employee or agent of a participating provider. In no case will Wellcare by Health Net be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Wellcare by Health Net, maintain the physician-patient relationship with the member. Wellcare by Health Net is not a provider of health care.

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## E. Health care plan fraud

**Health care plan fraud is defined as a deception or misrepresentation by a provider, member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by, for example, filing a claim that contains a false or deceptive statement is guilty of health care plan fraud.**

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-800-977-3565 (TTY: 711). The Fraud Hotline operates 24 hours a day, 7 days a week, 365 days a year. All calls are strictly confidential.

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## F. Circumstances beyond Wellcare by Health Net's control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in Wellcare by Health Net's facilities or personnel not being available to provide or arrange for services or benefits under this *Member Handbook*, Wellcare by Health Net's obligation to provide such services or benefits shall be limited to the requirement that Wellcare by Health Net make a good-faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





## 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 Member Services.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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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.

**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**, Section E, page 198 of your *Member Handbook* explains appeals, including how to make an appeal.

**Behavioral Health:** An all-inclusive term referring to mental health and substance use disorders.

**Brand name drug:** A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

**Care 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.

**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.”

**Centers for Medicare & Medicaid Services (CMS):** The federal agency in charge of Medicare. **Chapter 2**, Section G, page 31 of your *Member Handbook* explains how to contact CMS.

**Community-Based Adult Services (CBAS):** Outpatient, facility-based service program that delivers skilled nursing care, social services, occupational and speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services to eligible members who meet applicable eligibility criteria.

**Complaint:** A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**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.

**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**, Section E, page 198 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.

**Department of Health Care Services (DHCS):** The state department in California that administers the Medicaid Program (known as Medi-Cal).

**Department of Managed Health Care (DMHC):** The state department in California responsible for regulating health plans. DMHC helps people with appeals and complaints about Medi-Cal services. DMHC also conducts Independent Medical Reviews (IMR).

**Disenrollment:** The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dual eligible special needs plan (D-SNP):** Health plan that serves individuals who are eligible for both Medicare and Medi-Cal. Our plan is a D-SNP.

**Durable medical equipment (DME):** Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

**Emergency:** A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be a serious injury or severe pain.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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**Emergency care:** Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

**Exception:** Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

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

**Generic drug:** A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

**Grievance:** A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

**Health Insurance Counseling and Advocacy Program (HICAP):** A program that provides free and objective information and counseling about Medicare. **Chapter 2**, Section E, page 29 of your *Member Handbook* explains how to contact HICAP.

**Health plan:** An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

**Health risk assessment:** A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

**Home health aide:** A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

**Hospice:** A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**Improper/inappropriate billing:** A situation when a provider (such as a doctor or hospital) bills you more than our cost sharing amount for services. Call Member Services if you get any bills you don't understand.

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.

**Independent Medical Review (IMR):** If we deny your request for medical services or treatment, you can make an appeal. If you disagree with our decision and your problem is about a Medi-Cal service, including DME supplies and drugs, you can ask the California Department of Managed Health Care for an IMR. An IMR is a review of your case by doctors who are not part of our plan. If the IMR decision is in your favor, we must give you the service or treatment you asked for. You pay no costs for an IMR.

**Individualized Care Plan (ICP or Care Plan):** A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

**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.

**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 home or hospital. LTSS include Community Based Adult Services (CBAS) and Nursing Facilities (NF).

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

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

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

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**If you have questions,** please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- Refer to **Chapter 2**, Section H, page 32 of your *Member Handbook* for information about how to contact Medi-Cal.

**Medi-Cal plans:** Plans that cover only Medi-Cal benefits, such as long-term services and supports, medical equipment, and transportation. Medicare benefits are separate.

**Medically necessary:** This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice. Medically necessary refers to all covered services that are within reason and needed to protect life, prevent serious illness or disability, or to relieve severe pain through the diagnosis or treatment of disease, illness or injury.

**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-covered services:** Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Part B.

**Medicare-Medi-Cal enrollee:** A person who qualifies for Medicare and Medi-Cal coverage. A Medicare-Medi-Cal enrollee is also called a “dually eligible individual.”

**Medicare Part A:** The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711).

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**Medicare Part B:** The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

**Medicare Part C:** The Medicare program, also known as “Medicare Advantage” or “MA” that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

**Medicare Part D:** The Medicare prescription drug benefit program. We call this program “Part D” for short. Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medi-Cal. Our plan includes Medicare Part D.

**Medicare Part D drugs:** Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Part D. Medi-Cal may cover some of these drugs.

**Medication Therapy Management:** A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5**, Section G2, page 152 of your *Member Handbook* for more information.

**Member (member of our plan, or plan member):** A person with Medicare and Medi-Cal who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

**Member Handbook and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

**Member Services:** A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2**, Section A, page 20 of your *Member Handbook* for more information about Member Services.

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

**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.

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- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers.”

**Nursing home or facility:** A place that provides care for people who can’t get their care at home but don’t need to be in the hospital.

**Ombudsman:** An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman’s services are free. You can find more information in **Chapter 2**, Section I, page 33 and **Chapter 9**, Section D, page 197 of your *Member Handbook*.

**Organization determination:** Our plan makes an organization determination when we, or one of our providers, make a decision about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions.” **Chapter 9**, Section E, page 198 of your *Member Handbook* explains coverage decisions.

**Original Medicare (traditional Medicare or fee-for-service Medicare):** The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don’t want to be in our plan, you can choose Original Medicare.

**Out-of-network pharmacy:** A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn’t cover most drugs you get from 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**, Section D4, page 54 of your *Member Handbook* explains out-of-network providers or facilities.

**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.

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**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).





**Part A:** Refer to “Medicare Part A.”

**Part B:** Refer to “Medicare Part B.”

**Part C:** Refer to “Medicare Part C.”

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

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

**Personal health information (also called Protected health information) (PHI):**

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

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

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3**, Section D, page 49 of your *Member Handbook* for information about getting care from primary care providers.

**Prior authorization:** An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don’t get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets prior authorization from us.

- Covered services that need our plan’s prior authorization are marked in **Chapter 4**, Section D, page 75 of your *Member Handbook*.

Our plan covers some drugs only if you get prior authorization from us.

- Covered drugs that need our plan’s prior authorization are marked in the *List of Covered Drugs*.

**Program for All-Inclusive Care for the Elderly (PACE):** A program that covers Medicare and Medi-Cal benefits together for people age 55 and older who need a higher level of care to live at home.

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to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).



**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**, Section F, page 29 of your *Member Handbook* for information about the QIO.

**Quantity limits:** A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

**Referral:** A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3**, Section B, page 45 and **Chapter 4**, Section D, page 75 of your *Member Handbook*.

**Rehabilitation services:** Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4**, Section D page 75 of your *Member Handbook* to learn more about rehabilitation services.

**Sensitive services:** Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care and intimate partner violence.

**Service area:** A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get our plan.

**Share of cost:** The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

**Skilled nursing facility (SNF):** A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

**Skilled nursing facility (SNF) care:** Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

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**Specialist:** A doctor who provides health care for a specific disease or part of the body.

**Specialized pharmacy:** Refer to Chapter 5, Section A5, page 139 of your *Member Handbook* to learn more about specialized pharmacies.

**State Hearing:** If your doctor or other provider asks for a Medi-Cal service that we won't approve, or we won't continue to pay for a Medi-Cal service you already have, you can ask for a State Hearing. If the State Hearing is decided in your favor, we must give you the service you asked for.

**Step therapy:** A coverage rule that requires you to try another drug before we cover the drug you ask for.

**Supplemental Security Income (SSI):** A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits. SSI automatically provides Medi-Cal coverage.

**Urgent care:** Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

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## Nondiscrimination Notice

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

Wellcare by Health Net provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact Wellcare by Health Net by calling **1-800-431-9007**. Between October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. If you cannot hear or speak well, please call **TTY 711**. Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, please call or write to:

Wellcare by Health Net  
21281 Burbank Blvd.  
Woodland Hills, CA 91367  
**1-800-431-9007**  
**TTY: 711**

## How to File a Grievance

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

- **By phone:** Contact Wellcare by Health Net's Civil Rights Coordinator by calling **1-866-458-2208**. Between 8 a.m. and 5 p.m., Monday through Friday. Or, if you cannot hear or speak well, please call **TTY 711**.
- **In writing:** Fill out a complaint form or write a letter and send it to:  
Wellcare Civil Rights Coordinator  
P.O. Box 9103  
Van Nuys, CA 91409-9103
- **In person:** Visit your doctor's office or Wellcare by Health Net and say you want to file a grievance.
- **Electronically:** Visit Wellcare by Health Net's website at **[www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA)**.

## Office of Civil Rights – California Department of Health Care Services

You can also file a civil rights complaint with the California 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 **TTY 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**.

## Office of Civil Rights – U.S. Department of Health and Human Services

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

- **By phone:** Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- **In writing:** Fill out a complaint form or send a letter to:  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.
- **Electronically:** Visit the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

**English:** ATTENTION: If you need help in your language call **1-800-431-9007** (TTY: **711**). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call **1-800-431-9007** (TTY: **711**). These services are free of charge.

**العربية (Arabic):** انتباه: إذا كنت بحاجة إلى مساعدة بلغتك، فاتصل على الرقم **1-800-431-9007** (TTY: **711**) تتوفر أيضًا مساعدات وخدمات للأشخاص ذوي الإعاقات مثل المستندات بطريقة برايل وبطباعة كبيرة. اتصل على الرقم **1-800-431-9007** (TTY: **711**) وهذه الخدمات مجانية.

**Հայերեն (Armenian):** Ուշադրություն. Եթե Ձեր լեզվով օգնության կարիք ունեք, զանգահարեք **1-800-431-9007** (TTY` **711**): Հասանելի են նաև օգնություն և ծառայություններ հաշմանդամություն ունեցող անձանց համար, ինչպիսիք են՝ բրայլային և խոշոր տառերով փաստաթղթերը: Չանգահարեք **1-800-431- 9007** (TTY` **711**): Այս ծառայություններն անվճար են:

**ភាសាខ្មែរ (Cambodian):** ចំណាំ: ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសាបស្ចិម សូមទូរសព្ទទៅលេខ **1-800-431-9007** (TTY: **711**)។ ជំនួយនិងសេវាកម្មសម្រាប់ជនពិការ ដូចជាឯកសារជាអក្សរធំសម្រាប់ជនពិការភ្នែក និងពុម្ពអក្សរធំ ក៏មានផងដែរ។ សូមទូរសព្ទទៅលេខ **1-800-431- 9007** (TTY: **711**)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃនោះទេ។

**中文 (Chinese):** 注意: 如果您需要以您母语提供的协助, 请致电 **1-800-431-9007** (TTY: **711**)。我们也为残疾人士提供辅助和服务, 例如点字和大字体印刷的文件。请致电 **1-800-431-9007** (TTY: **711**)。这些服务为免费服务。

**فارسی (Farsi):** توجه: اگر نیاز به کمک به زبان خودتان دارید با شماره **1-800-431-9007** (TTY: **711**) تماس بگیرید. کمک‌ها و خدمات برای افراد دارای معلولیت نیز در دسترس است, مانند اسناد با خط بریل و چاپ درشت. با شماره **1-800-431-9007** (TTY **711**) تماس بگیرید. این خدمات رایگان است.

**हिंदी (Hindi):** ध्यान दें: अगर आपको अपनी भाषा में मदद चाहिए, तो **1-800-431-9007** (TTY: **711**) पर कॉल करें. विकलांग लोगों के लिए ब्रेल और बड़े प्रिंट में दस्तावेज़ जैसी सहायता और सेवाएं उपलब्ध हैं. **1-800-431-9007** (TTY: **711**) पर कॉल करें. ये सेवाएं नि:शुल्क हैं.

**Lus Hmoob (Hmong):** TSEEM CEEB: : Yog koj xav tau kev pab ua koj hom lus hu rau **1-800-431-9007** (TTY: **711**). Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam rau cov neeg xiam oob qhab, xws li cov ntaub ntawv Ua Ntawv Su thiab cov ntawv loj. Hu rau **1-800-431-9007** (TTY: **711**). Cov kev pab cuam no yog pab dawb xwb.

**日本語 (Japanese):** 注意: 言語のヘルプが必要な場合は **1-800-431-9007** (TTY: **711**) までお電話ください。障害をお持ちの方には、点字や大判プリントなどの補助機能やサービスもご利用になれます。 **1-800-431-9007** (TTY: **711**) までお電話ください。これらのサービスは無料です。

**한국어(Korean):** 주의: 귀하의 구사 언어로 도움을 받으셔야 한다면 **1-800-431-9007** (TTY: **711**) 번으로 연락해 주십시오. 점자 및 큰 활자 인쇄 형식으로 된 문서 등 장애인을 위한 도움 및 서비스도 제공됩니다. **1-800-431-9007**(TTY: **711**)번으로 연락해 주십시오. 해당 서비스는 무료로 제공됩니다.

**ພາສາລາວ (Laotian):** ສໍາຄັນ: ຖ້າວ່າທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານ ໂທ **1-800-431-9007** (TTY: **711**). ນອກຈາກນີ້ ຍັງມີການຊ່ວຍເຫຼືອ ແລະ ບໍລິການສໍາລັບຄົນພິການ ເຊັ່ນ: ເອກະສານທີ່ເປັນຕົວອັກສອນ ນູນ ແລະ ຕົວພິມຂະໜາດໃຫຍ່ ໂທ **1-800-431-9007** (TTY: **711**). ການບໍລິການເຫຼົ່ານີ້ແມ່ນພຣີ

**Mienh (Mien):** Liouh Eix: Oix se meih oix nongc zuqc gorngv mienh wac daih taengx meih, cingv meih mboqv dienx wac **1-800-431-9007** (TTY: **711**). Yie mbuo hac haih nongc mienh wac daih taengx waic fangx nyei mienh, hnangv zing mangc mv buatc lamh nyei mienh nongc nyei nzangc caux domh nzangc wenh jienx. Cingv meih mboqv dienx wac **1-800-431-9007** (TTY: **711**). Naiv deix bong zouc gong se maiv siou zinh nyanh nyei.



**ਪੰਜਾਬੀ (Punjabi):** ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ **1-800-431-9007** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ। ਅਪੰਗਤਾਵਾਂ ਵਾਲੇ ਲੋਕਾਂ ਵਾਸਤੇ ਸਹਾਇਤਾਵਾਂ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬਰੇਲ ਲਿਪੀ ਅਤੇ ਵੱਡੇ ਛਾਪੇ ਵਾਲੇ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ। **1-800-431-9007** 'ਤੇ ਕਾਲ ਕਰੋ (TTY: **711**)। ਇਹ ਸੇਵਾਵਾਂ ਮੁਫ਼ਤ ਹਨ।

**Русский (Russian):** ВНИМАНИЕ: если вам требуется помощь на родном языке, позвоните по номеру **1-800-431-9007** (телетайп: **711**). Также доступны сопутствующая помощь и услуги для людей с ограниченными возможностями, такие как материалы, напечатанные крупным шрифтом и шрифтом Брайля. Позвоните по номеру **1-800-431-9007** (телетайп: **711**). Эти услуги предоставляются бесплатно.

**Español (Spanish):** ATENCIÓN: Si necesita ayuda en su idioma llame al **1-800-431-9007** (TTY: **711**). También están disponibles ayudas y servicios para personas con discapacidades, como documentos en Braille y letra grande. Llame al **1-800-431-9007** (TTY: **711**). Estos servicios son gratuitos.

**Tagalog (Tagalog):** PAALALA: Kung kailangan ninyo ng tulong sa inyong wika, tumawag sa **1-800-431-9007** (TTY: **711**). Available din ang mga tulong at serbisyo para sa mga taong may kapansanan, gaya ng mga dokumento sa braille at malaking print. Tumawag sa **1-800-431-9007** (TTY: **711**). Walang bayad ang mga serbisyo ng ito.

**ภาษาไทย (Thai):** หมายเหตุ: หากต้องการความช่วยเหลือในภาษาของคุณ โปรดโทรไปท **1-800-431-9007** (TTY: **711**) เรามีความช่วยเหลือและบริการสำหรับผู้พิการ เช่น เอกสารที่เป็นอักษรเบรลล์และเอกสารที่ใช้ตัวอักษรขนาดใหญ่ ด้วยเช่นกัน โปรดโทรไปที่ **1-800-431-9007** (TTY: **711**) บริการเหล่านี้ไม่มีค่าใช้จ่าย

**Українська (Ukrainian):** УВАГА! Якщо ви потребуєте підтримки своєю мовою, телефонуйте за номером **1-800-431-9007** (TTY: **711**). Також доступні засоби та послуги для людей з обмеженими можливостями, як-от документи шрифтом Брайля та великим шрифтом. Телефонуйте за номером **1-800-431-9007** (TTY: **711**). Ці послуги є безкоштовними.

**Tiếng Việt (Vietnamese):** CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của quý vị, hãy gọi số **1-800-431-9007** (TTY: **711**). Các hỗ trợ và dịch vụ dành cho người khuyết tật, chẳng hạn như tài liệu bằng chữ nổi và chữ chữ lớn cũng được cung cấp. Hãy gọi số **1-800-431-9007** (TTY: **711**). Các dịch vụ này được miễn phí.

## Wellcare by Health Net Member Services

<b>CALL</b>	<p>1-800-431-9007</p> <p>Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
<b>TTY</b>	<p>711</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. However, please note during weekends and holidays from April 1 to September 30 our automated phone system may answer your call. Please leave your name and telephone number, and we will call you back within one (1) business day.</p>
<b>WRITE</b>	<p>Wellcare by Health Net PO Box 748658 Los Angeles, CA 90074-8658</p>
<b>WEBSITE</b>	<p><a href="http://www.wellcare.com/healthnetCA">www.wellcare.com/healthnetCA</a></p>

**If you have questions**, please call Wellcare by Health Net at 1-800-431-9007 (TTY: 711). Between October 1 and March 31, representatives are available Monday–Sunday, 8 a.m. to 8 p.m. Between April 1 and September 30, representatives are available Monday–Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit [www.wellcare.com/healthnetCA](http://www.wellcare.com/healthnetCA).

