



Santa Clara Family
Health Plan™

CAL MEDICONNECT PLAN

(Medicare-Medicaid Plan)

Member Handbook 2021

Customer Service: **1-877-723-4795**

TTY: **711**

Monday through Friday, 8 a.m. to 8 p.m. The call is free.

www.scfhp.com

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Santa Clara Family Health Plan Cal MediConnect Plan (Medicare-Medicaid Plan) *Member Handbook*

January 1, 2021 – December 31, 2021

Your Health and Drug Coverage under Santa Clara Family Health Plan Cal MediConnect Plan (Medicare-Medicaid Plan)

Member Handbook Introduction

This handbook tells you about your coverage under Santa Clara Family Health Plan Cal MediConnect through December 31, 2021. 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 (LTSS) 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 the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

This Cal MediConnect Plan is offered by Santa Clara Family Health Plan (SCFHP). When this *Member Handbook* says “we,” “us,” or “our,” it means SCFHP. When it says “the plan” or “our plan,” it means SCFHP Cal MediConnect.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free.

ATENCIÓN: Si habla español, hay servicios de ayuda de idiomas gratis disponibles para usted. Llame a Servicio al Cliente al 1-877-723-4795 (TTY: 711) de lunes a viernes, de 8 a.m. a 8 p.m. La llamada es gratis.

CHÚ Ý: Nếu quý vị nói tiếng Việt, có dịch vụ hỗ trợ ngôn ngữ, miễn phí dành cho quý vị. Hãy gọi đến Dịch Vụ Khách Hàng theo số 1-877-723-4795 (TTY: 711), từ Thứ Hai đến Thứ Sáu, 8 giờ sáng đến 8 giờ tối. Cuộc gọi là miễn phí.

注意：如果您说中文，您可申请免费语言援助服务。请于星期一至星期五早上 8 点至晚上 8 点致电 1-877-723-4795（TTY 用户请致电 711）与客户服务部联系。本电话免费。

PAUNAWA: Kung nagsasalita ka ng Tagalog, may magagamit kang mga serbisyong tulong sa wika na walang bayad. Tumawag sa Serbisyo para sa Mamimili sa 1-877-723-4795 (TTY: 711), Lunes hanggang Biyernes, 8 a.m. hanggang 8 p.m. Ang pagtawag ay libre.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 월요일부터 금요일 오전 8시부터 저녁 8시까지 1-877-723-4795 (TTY: 711)번으로 고객 서비스부에 연락해 주십시오. 통화는 무료입니다.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ապա լեզվական օգնության ծառայությունները Ձեզ կտրամադրվեն անվճար: Չանգահարեք հաճախորդների սպասարկման կենտրոն հետևյալ հեռախոսահամարով՝ 1-877-723-4795 (TTY. 711), երկուշաբթիից ուրբաթ՝ ժ. 8:00 - 20:00: Չանգն անվճար է:

ВНИМАНИЕ: Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами переводчика. Позвоните в Службу поддержки клиентов по номеру 1-877-723-4795 (телетайп: 711), с понедельника по пятницу, с 8:00 до 20:00. Звонок бесплатный.

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک‌زبانی به‌صورت رایگان در دسترس شما قرار دارد. روزهای دوشنبه تا جمعه، از 8 صبح الی 8 شب، با واحد خدمات مشتریان به شماره 1-877-723-4795 (TTY: 711) تماس بگیرید. تماس با این شماره رایگان است.

ご注意：日本語を話される場合、無料の言語支援サービスをご利用いただけます。カスタマーサービス 1-877-723-4795 (TTY : 711) までお電話下さい。サービス時間帯は月曜日から金曜日の午前 8 時から午後 8 時までです。通話は無料です。

LUS CEEV: Yog hais tias koj hais lus Hmoob, peb muaj kev pab txhais lus pub dawb rau koj. Hu rau Lub Chaw Pab Cuam Neeg Qhua rau ntawm tus xov tooj 1-877-723-4795 (TTY: 711), hnuv Monday txog Friday, 8 teev sawv ntxov txog 8 teev tsaus ntu. Qhov hu no yog hu dawb xwb.

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। 1-877-723-4795 (TTY: 711) 'ਤੇ ਗਾਹਕ ਸੇਵਾ ਨੂੰ ਸੋਮਵਾਰ ਤੋਂ ਸ਼ੁੱਕਰਵਾਰ, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਰਾਤੀਂ 8 ਵਜੇ ਤੱਕ ਕਾਲ ਕਰੋ। ਕਾਲ ਕਰਨ ਦਾ ਪੈਸਾ ਨਹੀਂ ਲੱਗਦਾ।

إنتباه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الاتصال بخدمة العملاء على الرقم 1-877-723-4795 (الهاتف النصي لضعاف السمع (TTY: 711) من الاثنين إلى الجمعة، من 8 صباحًا إلى 8 مساءً. الاتصال مجاني.

ध्यान दें: अगर आप हिंदी, भाषा बोलते हैं, तो आपके लिए भाषा सहायता सेवाएँ निःशुल्क उपलब्ध हैं। ग्राहक सेवा को 1-877-723-4795 (TTY: 711) पर, सोमवार से शुक्रवार, सुबह 8:00 से शाम 8:00 बजे तक कॉल करें यह कॉल निःशुल्क है।

โปรดทราบ: หากท่านพูดภาษาไทย จะมีบริการความช่วยเหลือทางด้านภาษาโดยไม่มีค่าใช้จ่าย ติดต่อศูนย์บริการลูกค้าได้ที่ 1-877-723-4795 (TTY: 711) ได้ในวันจันทร์ถึงศุกร์ เวลา 08.00 น. ถึง 20.00 น. ไม่มีค่าใช้จ่ายในการโทร

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



ຜູ້ອຸທິດ: ບຸກຄົນເປັນເລກກູ້ຄືພາຍກາສາ
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ຮູບສັນຍາຜູ້ຮັບຮອງການສະໜອງບໍລິການແກ້ໄຂບັນຫາສຳລັບຄົນເຮືອນ 1-877-723-4795 (TTY: 711)
ຕັ້ງຜູ້ຮັບຮອງຜູ້ສຸກເຮືອນ 8 ຕື້ກຳ ຊຸມເຮືອນ 8 ພັດ ການເຮັດຮູບສັນຍາສຳລັບຄົນເຮືອນ

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຄິດຄ່າໃຊ້ຈ່າຍ
ສໍາລັບທ່ານ. ໂທຫາສູນບໍລິການລູກຄ້າໄດ້ທິເບີ 1-877-723-4795 (TTY: 711), ວັນຈັນ ຫາ ວັນສຸກ
ເວລາ 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ. ໂທຟຣີ.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free.

You can make a standing request to get this document, now and in the future, in a language other than English or in an alternate format. We will keep this information on file for future mailings. You do not need to make a separate request each time. To make or change your request call SCFHP Cal MediConnect Customer Service or send a request in writing to:

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Santa Clara Family Health Plan Cal MediConnect

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Disclaimers

- Santa Clara Family Health Plan Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.
- Coverage under Santa Clara Family Health Plan Cal MediConnect 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 for more information on the individual shared responsibility requirement.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 1: Getting started as a member

Introduction

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

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



A. Welcome to Santa Clara Family Health Plan Cal MediConnect Plan

SCFHP Cal MediConnect is a Cal MediConnect Plan. A Cal MediConnect Plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. It also has case managers and care teams to help you manage all your providers and services. They all work together to provide the care you need.

SCFHP Cal MediConnect was approved by the State of California and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of Cal MediConnect.

Cal MediConnect is a demonstration program jointly monitored by California and the federal government to provide better care for people who have both Medicare and Medi-Cal. Under this demonstration, the state and federal government want to test new ways to improve how you get your Medicare and Medi-Cal services.

Thank you for choosing SCFHP Cal MediConnect. SCFHP is a local, public, not-for-profit health plan dedicated to improving the health and well-being of the residents of Santa Clara County. We look forward to serving you. Our job is to see that our members receive good quality health care. Our pledge to you is that we will constantly work to meet this goal.

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

B2. Medi-Cal

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



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Each state decides:

- what counts as income and resources,
- who qualifies,
- 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 California approved SCFHP Cal MediConnect 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 will not be affected.

C. Advantages of this plan

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

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

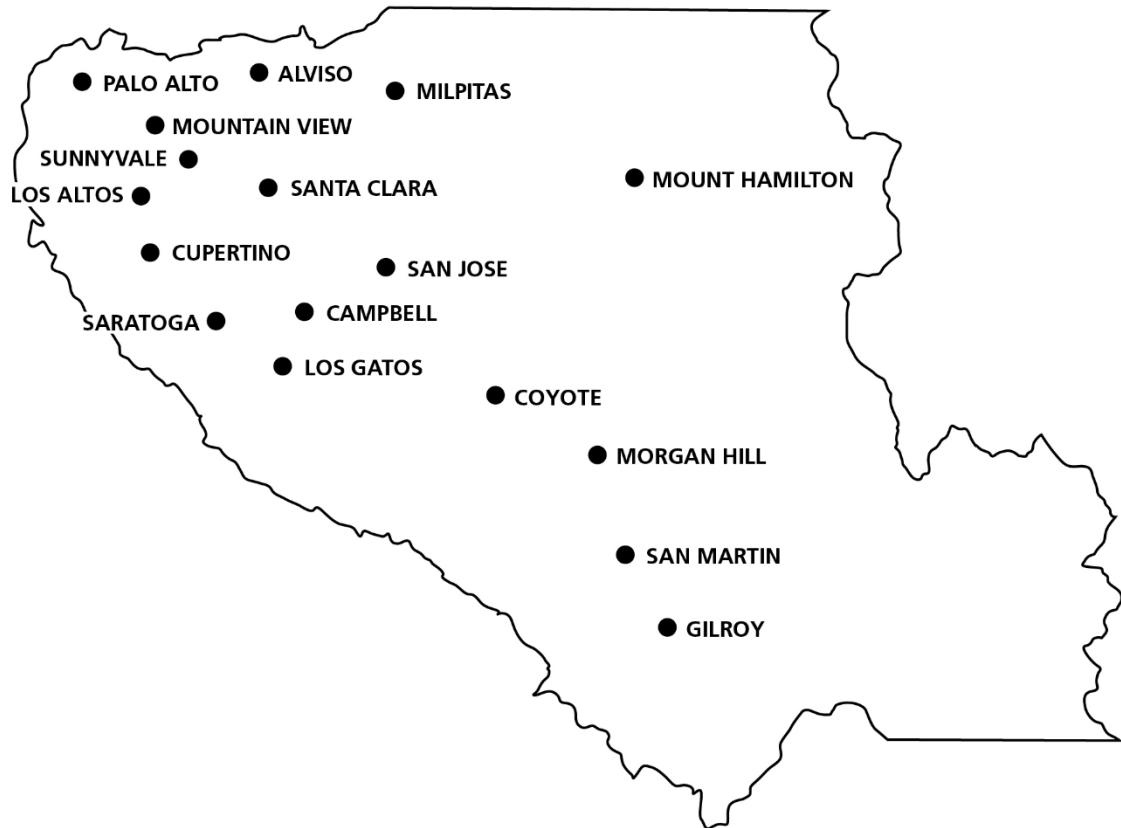
- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You will have access to a case manager. This is a person who works with you, with SCFHP Cal MediConnect, and with your care team to help make a care plan.
- You will be able to direct your own care with help from your care team and case manager.
- The care team and case manager will work with you to come up with a care plan specifically designed to meet your health needs. The care team will help coordinate the services you need. This means, for example:

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- Your care team will make sure your doctors know about all the medicines you take so they can make sure you are taking the right medicines, and so your doctors can reduce any side effects you may have from the medicines.
- Your care team will make sure your test results are shared with all your doctors and other providers, as appropriate.

D. SCFHP Cal MediConnect's service area



Our service area is Santa Clara County.

Only people who live in our service area can join SCFHP Cal MediConnect.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

If you move outside of our service area, you cannot stay in this plan. See Chapter 8, Section I, page 164 for more information about the effects of moving out of our service area. You will need to contact your local county eligibility worker:

Social Services Agency, Santa Clara County

CALL	1-877-96-BENEFITS (1-877-962-3633) or 1-408-758-4600 Available 24 hours a day, 7 days a week
TTY	711
WEBSITE	www.MyBenefitsCalWIN.org or www.sccgov.org/sites/ssa/Pages/default.aspx

Application Assistance Center

CALL	1-408-758-3800
TTY	1-408-758-3822
LOCATION	1867 Senter Road San Jose, CA 95112
WEBSITE	www.sccgov.org/sites/ssa/Pages/default.aspx

North County Office

CALL	1-650-988-6200 Monday through Friday, 8 a.m. to 5 p.m.
TTY	1-408-278-2403
LOCATION	1330 W. Middlefield Road Mountain View, CA 94043
WEBSITE	www.sccgov.org/sites/ssa/Pages/default.aspx

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



South County Office

CALL	1-408-758-3300 Monday through Friday, 8 a.m. to 5 p.m.
TTY	1-408-758-3475
LOCATION	379 Tomkins Court Gilroy, CA 95020
WEBSITE	www.sccgov.org/sites/ssa/Pages/default.aspx

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- Live in our service area, **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, have full Medi-Cal benefits and meet any share of cost, **and**
- Are a United States citizen or are lawfully present in the United States.

There may be additional eligibility rules in your county. Call Customer Service for more information.

F. What to expect when you first join a health plan

When you first join the plan, you will get a health risk assessment (HRA) within the first 90 calendar days for low-risk members or 45 calendar days for high-risk members.

We are required to complete an HRA for you. This HRA is the basis for developing your individual care plan (ICP). The HRA will include questions to identify your medical, LTSS, and behavioral health and functional needs.

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

We will send you more information regarding this HRA.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

If **SCFHP Cal MediConnect is new for you**, you can keep seeing the doctors you go to now for a certain amount of time. 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 makes a direct request to us to continue to see your current provider.
- We can 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 SCFHP Cal MediConnect.
 - We will determine an existing relationship by reviewing your health information available to us or information you give us.
 - We have 30 days to respond to your request. You may also 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: This request **cannot** be made for providers of Durable Medical Equipment (DME), transportation, other ancillary services, or services not included under Cal MediConnect.

After the continuity of care period ends, you will need to see doctors and other providers in the SCFHP Cal MediConnect network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. See Chapter 3, Section B, page 43 for more information on getting care.

G. Your Care Team and Care Plan

G1. Care Team

Do you need help getting the care you need? A care team can help you. A care team may include your doctor, a case manager, or other health person that you choose.

A case manager is a person who is trained to help you manage the care you need. You will get a case manager when you enroll in SCFHP Cal MediConnect. This person will also refer you to community resources, if SCFHP Cal MediConnect does not provide the services that you need.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



You can call us at 1-877-590-8999, Monday through Friday, 8:30 a.m. to 5:00 p.m. to ask for a care team.

G2. Care Plan

Your care team will work with you to come up with a care plan. A care plan tells you and your doctors what services you need, and how you will get them. It includes your medical, behavioral health, and LTSS needs. Your care plan will be made just for you and your needs.

Your care plan will include:

- Your health care goals.
- A timeline for when you should get the services you need.

After your health risk assessment, your care team will meet with you. They will talk to you about services you need. They can also tell you about services you may want to think about getting. Your care plan will be based on your needs. Your care team will work with you to update your care plan at least every year.

H. SCFHP Cal MediConnect monthly plan premium

SCFHP Cal MediConnect does not have a monthly plan premium.

I. The *Member Handbook*

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, page 165, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. You can also see the *Member Handbook* at www.scfhp.com or download it from this website. You will receive a notice of availability of the *Member Handbook* before the beginning of each new year.

The contract is in effect for the months you are enrolled in SCFHP Cal MediConnect between January 1, 2021 and December 31, 2021.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

J. Other information you will get form us

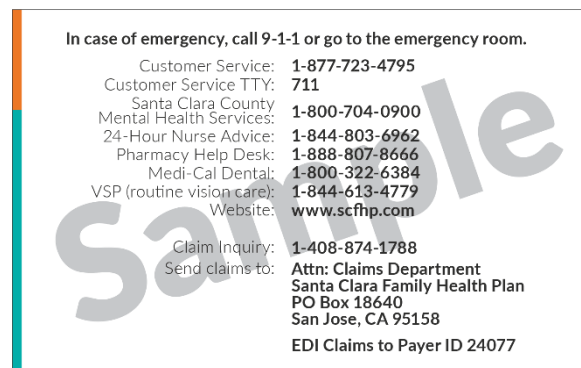
You should have already gotten an SCFHP Cal MediConnect Member ID Card, information about how to access a *Provider and Pharmacy Directory*, a List of Durable Medical Equipment, and information about how to access a *List of Covered Drugs*.

J1. Your SCFHP Cal MediConnect Member ID Card

Under our plan, you will have one card for your Medicare and Medi-Cal services, including long-term services and supports, certain behavioral health services, and prescriptions. You must show this card when you get any services or prescriptions. Here is a sample card to show you what yours will look like:



Front



Back

If your Cal MediConnect card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card. You can call SCFHP Cal MediConnect Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Medi-Cal card to get Cal MediConnect services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your SCFHP Cal MediConnect Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. See Chapter 7, Section A, page 147 to see what to do if you get a bill from a provider.

Please remember, for the specialty mental health services that you may get from the county mental health plan (MHP), you will need your Medi-Cal card to access those services.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the SCFHP Cal MediConnect network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see Section F, page 11).

You can ask for a *Provider and Pharmacy Directory* by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. You can also see the *Provider and Pharmacy Directory* at www.scfhp.com or download it from this website.

Information available in the directory includes provider name, phone number, address, specialty, license number, languages spoken, and more.

Definition of network providers

- SCFHP Cal MediConnect's network providers include:
 - Doctors, nurses, and other health care professionals that you can go to 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 have agreed to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies (drug stores) that have agreed 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 Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m., for more information. Both Customer Service and SCFHP Cal MediConnect's website can give you the most up-to-date information about changes in our network pharmacies and providers.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

List of Durable Medical Equipment (DME)

With this *Member Handbook*, we sent you SCFHP Cal MediConnect's List of Durable Medical Equipment. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at www.scfhp.com. See Chapter 4, Section D, page 75 to learn more about DME equipment.

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 are covered by SCFHP Cal MediConnect.

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. See Chapter 5, Section C, page 125 for more information on these rules and restrictions.

Each year, we will 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, visit www.scfhp.com or call 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

J4. The Explanation of Benefits

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

The EOB tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. The EOB has more information about the drugs you take. Chapter 6, page 135 gives more information about the EOB and how it can help you keep track of your drug coverage.

An EOB is also available when you ask for one. To get a copy, contact Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

K. How to keep your membership record up to date

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

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get**

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



and how much it will cost you. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation.
- Any liability claims, such as claims from an automobile accident.
- Admission to a nursing home or hospital.
- Care in a hospital or emergency room.
- Changes in who your caregiver (or anyone responsible for you) is.
- You are part of or become part of a clinical research study.

If any information changes, please let us know by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). State and federal laws require that we keep your PHI private. We make sure that your PHI is protected. For more details about how we protect your PHI, see Chapter 8, Section C, page 157.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Chapter 2: Important phone numbers and resources

Introduction

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

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

A. How to contact SCFHP Cal MediConnect Customer Service

CALL	<p>1-877-723-4795. This call is free.</p> <p>Monday through Friday, 8 a.m. to 8 p.m.</p> <p>If you call outside of the plan’s normal Customer Service hours, SCFHP Cal MediConnect has an interactive voice response system for your use or you can leave a voice mail and we will return your call within one business day. Visit www.scfhp.com for more information about SCFHP Cal MediConnect.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<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>Monday through Friday, 8 a.m. to 8 p.m.</p>
WRITE	<p>Attn: Customer Service Department Santa Clara Family Health Plan PO Box 18880 San Jose, CA 95158</p>
WEBSITE	<p>www.scfhp.com</p>

A1. When to contact Customer Service

- Questions about the plan
- Questions about claims, billing or Member ID Cards
- Coverage decisions about your health care
 - A coverage decision about your health care is a decision about:
 - Your benefits and covered services, **or**
 - The amount we will 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, see Chapter 9, Section DC, page 170.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- 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.
 - To learn more about making an appeal, see Chapter 9, Section DC, page 170.
- 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 the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F on page 27).
 - You can call us and explain your complaint. Call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
 - If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).
 - You can send a complaint about SCFHP Cal MediConnect to Medicare. You can use an online form at [medicare.gov/MedicareComplaintForm/home.aspx](https://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 SCFHP Cal MediConnect to the Cal MediConnect Ombuds Program by calling 1-855-501-3077 (TTY: 1-855-847-7914), Monday through Friday, 9 a.m. to 5 p.m.
 - To learn more about making a complaint about your health care, see Chapter 9, page 165.
- Coverage decisions about your drugs
 - A coverage decision about your drugs is a decision about:
 - Your benefits and covered drugs, **or**
 - The amount we will pay for your drugs.
 - This applies to your Part D drugs, Medi-Cal prescription drugs, and Medi-Cal over-the-counter drugs.
 - For more on coverage decisions about your prescription drugs, see Chapter 9, Section F, page 188.
- Appeals about your drugs
 - An appeal is a way to ask us to change a coverage decision.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- If you would like to make an appeal on a coverage decision for any of your drugs, contact SCFHP Cal MediConnect Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. Or go to www.scfhp.com to download the appeals and grievances form and mail to:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
- For more on making an appeal about your prescription drugs, see Chapter 9, page 165.
- Complaints about your drugs
 - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
 - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (See the section above.)
 - You can send a complaint about SCFHP Cal MediConnect to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
 - For more on making a complaint about your prescription drugs, see Chapter 9, Section F, page 188.
- Payment for health care or drugs you already paid for
 - For more on how to ask us to pay you back, or to pay a bill you got, see Chapter 7, Section A, page 147 and Section B, page 149.
 - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Section D, page 170 for more on appeals.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



B. How to contact your case manager

A case manager is a clinician or other trained person who provides care coordination services for you, especially during care transitions and hospital discharges. When you enroll in SCFHP Cal MediConnect, your health needs will be assessed and a case manager will be offered to help you. You may contact case management at the numbers below. To request to change your case manager, call SCFHP Cal MediConnect Case Management.

CALL	<p>1-877-590-8999. This call is free.</p> <p>Monday through Friday, 8:30 a.m. to 5 p.m.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<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>Monday through Friday, 8:30 a.m. to 5 p.m.</p>
WRITE	<p>Attn: Case Management Santa Clara Family Health Plan PO Box 18880 San Jose, CA 95158</p>
WEBSITE	<p>www.scfhp.com</p>

B1. When to contact your case manager

- 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 includes Community-Based Adult Services (CBAS), Multipurpose Senior Service Programs (MSSP), and Nursing Facilities (NF).

For information on eligibility requirements for LTSS, see How to get long-term services and supports (LTSS), Chapter 3, Section E, page 51. For additional information, please call Customer Service.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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),
- Multipurpose Senior Service Programs (MSSP),
- Skilled nursing care,
- Physical therapy,
- Occupational therapy,
- Speech therapy,
- Medical social services, and
- Home health care.

C. How to contact the Nurse Advice Call Line

When you have health care questions or concerns, call the SCFHP Nurse Advice Line. Our licensed health care professionals can help you 24 hours a day, 7 days a week. The Nurse Advice Line can help you with:

- Instructions on self-care at home
- What to do if you need care and a health care provider's office is closed
- Advice on whether you should get medical care
- How and where to get care
- Referral to telehealth providers

For example, if you are not sure if your condition is an emergency medical condition, Nurse Advice can help you decide if you need emergency services or urgent care.

In an emergency, you should always call 9-1-1, or go to the nearest hospital.

CALL	1-844-803-6962. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



TTY	<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>24 hours a day, 7 days a week.</p>
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C1. When to contact the Nurse Advice Line

- Questions about your health care.

D. How to contact the Behavioral Health Crisis Line

The Santa Clara County Behavioral Health Services Department Suicide and Crisis Services (SACS) provides support for individuals and families who are in crisis, struggling with mental illness, or substance abuse.

CALL	<p>1-855-278-4204. This call is free.</p> <p>24 hours a day, 7 days a week.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<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>24 hours a day, 7 days a week</p>
WEBSITE	<p>www.sccgov.org/sites/bhd/Pages/home.aspx</p>

D1. When to contact the Behavioral Health Crisis Line

- Questions about behavioral health and substance abuse services

For questions regarding your county specialty mental health services, go to Chapter 3, Section F, page 52.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

E. How to contact the Health Insurance Counseling & 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.

CALL	1-408-350-3200 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Sourcewise 3100 De La Cruz Blvd, Suite 310 Santa Clara, CA 95054
EMAIL	community@mysourcewise.com
WEBSITE	www.mysourcewise.com

E1. When to contact HICAP

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



F. How to contact the Quality Improvement Organization (QIO)

Our state has an organization called Livanta Beneficiary and Family Centered Care (BFCC)-Quality Improvement Organization (QIO). This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta BFCC-QIO is not connected with our plan.

CALL	1-877-588-1123 Available 24 hours a day, 7 days a week.
TTY	1-855-887-6668 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta BFCC-QIO 10520 Guilford Rd, Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livanta.com

F1. When to contact Livanta BFCC-QIO

- Questions about your health care
 - 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.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

G. How to contact 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.

CALL	<p>1-800-MEDICARE (1-800-633-4227)</p> <p>Calls to this number are free, 24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048. 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>
WEBSITE	<p>www.medicare.gov</p> <p>This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting “Forms, Help & Resources” and then clicking on “Phone numbers & websites.”</p> <p>The Medicare website has the following tool to help you find plans in your area:</p> <p>Medicare Plan Finder: Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Find plans.”</p> <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p>

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



H. How to contact Medi-Cal Health Care Options

Medi-Cal Health Care Options can help you if you have questions about selecting a Cal MediConnect plan or other enrollment issues.

CALL	<p>1-844-580-7272</p> <p>Health Care Options representatives are available between the hours of 8:00 a.m. and 6:00 p.m., Monday through Friday.</p>
TTY	<p>1-800-430-7077</p> <p>This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.</p>
WRITE	<p>California Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850</p>
WEBSITE	<p>www.healthcareoptions.dhcs.ca.gov/</p>



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

I. How to contact the Cal MediConnect Ombuds program

The Cal MediConnect Ombuds Program 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 Cal MediConnect Ombuds Program can also help you with service or billing problems. The Cal MediConnect Ombuds Program is not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-855-501-3077. This call is free. Monday through Friday, 9 a.m. to 5 p.m.
TTY	1-855-847-7914 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Ombudsman Santa Clara County Bay Area Legal Aid 4 N. Second Street, Suite 600 San Jose, CA 95113
WEBSITE	www.healthconsumer.org

J. How to contact County Social Services

If you need help with your Social Services benefits, contact your local County Social Services Department.

CALL	1-408-755-7100 Monday through Friday, 8 a.m. to 5 p.m.
WRITE	Social Services Agency Administration 353 West Julian Street San Jose, CA 95110
WEBSITE	www.sccgov.org/sites/ssa/about_us/Pages/ssa_contacts.aspx

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



K. How to contact your 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.

CALL	<p>Santa Clara County Behavioral Health Services Department 1-800-704-0900. This call is free.</p> <p>Monday through Friday, 8 a.m. to 5 p.m.</p> <p>We have free interpreter services for people who do not speak English.</p>
TTY	<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>Monday through Friday, 8 a.m. to 5 p.m.</p>

K1. Contact the county specialty mental health plan about:

- Questions about behavioral health services provided by the county.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

L. How to contact the 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 against your health plan about Medi-Cal services.

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



M. Other resources

The community resources listed below are provided as a public service. As part of your care plan, your SCFHP case manager can help connect you to these services. Note: SCFHP is not a sponsor of the organizations listed here. Additional resources are available on our website at www.scfhp.com.

Alzheimer's Association of Northern California

The Alzheimer's Association provides answers to questions about all aspects of Alzheimer's disease, community resources that support caregivers, and emotional support.

CALL	1-800-272-3900, Helpline. 1-408-372-9900, Main number. 24 hours a day, 7 days a week.
WRITE	2290 N First St, Suite 101 San Jose, CA 95131
WEBSITE	www.alz.org/norcal/

American Heart Association

Provides resources for various heart conditions, nutrition, and healthy living.

CALL	1-510-903-4050
WRITE	426 17 th St, Ste 300 Oakland, CA 94612
WEBSITE	www.heart.org/en/affiliates/california/greater-bay-area

Aunt Bertha

Aunt Bertha is a social care network that connects people and programs. The online platform makes it easy to find social services in the community based on ZIP codes.

WEBSITE	www.scfhp.auntbertha.com
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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

California Department of Rehabilitation, San Jose District Office

Provides vocational rehabilitation, training, and job placement services for individuals with disabilities.

CALL	1-408-277-1355
TTY	1-844-729-2800 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	100 Paseo de San Antonio, Room 324 San Jose, CA 95113-1479
WEBSITE	www.dor.ca.gov

California Department of Rehabilitation, Gilroy Branch

CALL	1-408-848-1345
TTY	1-844-729-2800 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	8060 Santa Teresa Blvd, Suite 200 Gilroy, CA 95020-3864
WEBSITE	www.dor.ca.gov

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



California Department of Rehabilitation, San Jose North Branch

CALL	1-669-207-0014
TTY	1-844-729-2800 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	2160 Lundy Ave, Suite 115 San Jose, CA 95131
WEBSITE	www.dor.ca.gov

California Smokers' Helpline

Provides counseling and resources to help participants quit smoking.

CALL	English – 1-800-987-2908 Spanish – 1-800-456-6386 Mandarin/Cantonese – 1-800-838-8917 Vietnamese – 1-800-778-8440
WEBSITE	www.nobutts.org/

Family Caregiver Alliance (FCA)

FCA provides community-based and online caregiver education, and links to resources and support groups.

CALL	1-800-445-8106 or 1-415-434-3388
WRITE	101 Montgomery St, Suite 2150 San Francisco, CA 94104
WEBSITE	www.caregiver.org



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Farmers' Markets

Most farmers' markets in Santa Clara County accept CalFresh EBT, making it easier to buy fresh, local produce in your neighborhood. When you use your CalFresh EBT card at a Market Match participating farmers' market, you can double your money, up to \$10 free per day.

CALL	1-408-793-2700
WRITE	1775 Story Rd, Suite 120 San Jose, CA 95122
WEBSITE	www.sccgov.org/sites/phd/hi/heal/Pages/calfresh.aspx

Friendship Line

Friendship Line is an accredited crisis line for people aged 60 years and older, and adults living with disabilities. Friendship Line provides on-going outreach calls to lonely older adults.

CALL	1-800-971-0016, 24-hour toll-free line
WEBSITE	www.ioaging.org/services/all-inclusive-health-care/friendship-line

In-Home Supportive Services (IHSS) Santa Clara County

A program that allows you to select your provider of in-home care if you cannot safely remain in your home without assistance. IHSS services may include but not be limited to: housecleaning, meal preparation, laundry, grocery shopping, personal care, accompaniment to medical appointments and other services.

CALL	1-408-792-1600 Monday through Friday, 8 a.m. to 5 p.m.
WRITE	1888 Senter Rd San Jose, CA 95112
WEBSITE	www.sccgov.org/sites/ssa/other-services/ihss/Pages/ihss.aspx

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Santa Clara County Adult Protective Services

Adult Protective Services receives and investigates reports of abuse or neglect regarding elders (age 65+) or dependent adults (ages 18 to 64 who because of mental or physical disability are unable to protect themselves and advocate on their own behalf).

CALL	1-408-975-4900 or 1-800-414-2002, 24-hour report line.
WRITE	333 W Julian St, 4th Floor San Jose, CA 95110
WEBSITE	www.sccgov.org/sites/da/prosecution/DistrictAttorneyDepartments/Pages/ElderDepAdultAbuseReporting.aspx

SCFHP Cal MediConnect Fraud Hotline

If you think fraud is being committed by someone who provides your health care services or supplies, contact the SCFHP Cal MediConnect Fraud hotline.

CALL	1-408-874-1450 Available 24 hours a day, 7 days a week
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Attn: Compliance Officer Santa Clara Family Health Plan PO Box 18880 San Jose, CA 95158
FAX	1-408-874-1970
WEBSITE	www.scfhp.com

For more information on fraud, waste, and abuse, see Chapter 11, Section G, page 241.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Second Harvest Food Bank (SHFB)

Through a variety of programs and services, the Food Bank provides food to people in need where they live, learn, and work. Call SHFB to be connected with resources like free food and CalFresh. Food Connection is Second Harvest’s toll-free hotline that helps people in need of food find resources in their neighborhood. Multilingual staff members direct callers to local food assistance programs.

CALL	1-800-984-3663
WEBSITE	www.shfb.org

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Senior Adult Legal Assistance (SALA)

SALA provides legal assistance and education through a network of senior centers. They specialize in public benefits, long-term care, elder abuse, housing issues, planning for incapacity, probate alternatives and simple wills.

CALL	Central Office – 1-408-295-5991 North County – 1-650-969-8656 South County – 1-408-847-7252 Monday through Friday, 9 a.m. to 5 p.m.
WRITE	1425 Koll Circle, Suite 109 San Jose, CA 95112
WEBSITE	www.sala.org

Senior Nutrition Program – Home Meal Delivery (Meals on Wheels)

Nutritious meals offered to eligible seniors (age 60+) at community sites located throughout the county and through Meals on Wheels programs.

CALL	Senior Nutrition Program – 1-408-975-4860 Meals on Wheels Enrollment – 1-408-350-3246
WRITE	333 W Julian St, 4th Floor San Jose, CA 95110
FAX	1-408-975-4830
WEBSITE	www.sccgov.org/sites/ssa/food-assistance/snp/Pages/meals_on_wheels.aspx



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Silicon Valley Independent Living Center (SVILC)

SVILC’s core programs include: independent living skills training, information and referral, peer counseling, mentorship and training, and advocacy for systems and individual consumers. SVILC also provides assistive technology services, the Community Transitions Program that helps individuals transition from nursing facilities into community-based housing, and assistance with housing and personal assistant (PA) services.

Silicon Valley Independent Living Center (SVILC) – Main Office

CALL	1-408-894-9041
TTY	1-408-894-9012 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	25 N. 14th St., Suite 1000 San Jose, CA, 95112
FAX	1-408-894-9050
WEBSITE	www.svilc.org/

Silicon Valley Independent Living Center (SVILC) – South County Branch Office

CALL	1-408-843-9100
TTY	1-408-894-9012 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	7881 Church St, Suite C Gilroy, CA 95020
FAX	1-408-842-4791
WEBSITE	www.svilc.org/

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Social Security Administration

CALL	1-800-772-1213 Monday through Friday, 7 a.m. to 7 p.m.
TTY	1-800-325-0778 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Social Security Administration Office of Public Inquiries and Communications Support 1100 West High Rise 6401 Security Blvd Baltimore, MD 21235
WEBSITE	www.socialsecurity.gov

Sourcewise

Sourcewise serves as the local Area Agency on Aging. Sourcewise provides access to a comprehensive database of community resources for older adults and their caregivers, through their call center and website. They also offer information and awareness services, a senior employment program, Health Insurance Counseling & Advocacy Program (HICAP), and care management.

CALL	1-408-350-3200 Monday through Friday, 8 a.m. to 5 p.m.
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	3100 De La Cruz Blvd, Suite 310 Santa Clara, CA 95054
EMAIL	community@mysourcewise.com
WEBSITE	www.mysourcewise.com



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

The Health Trust Meals on Wheels Program

The Health Trust Meals on Wheels Program serves physically challenged, homebound individuals, whether they are elderly, are recuperating from a recent hospitalization or have disabilities confining them to a wheelchair. Hot, nutritious meals are delivered 5 days a week, along with frozen meals for preparation on the weekend. Drivers also provide daily wellness checks.

CALL	1-408-961-9870 or 1-800-505-3367
EMAIL	mow@healthtrust.org
WEBSITE	healthtrust.org/provider/food/

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with SCFHP Cal MediConnect. It also tells you about your case manager, 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 when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



A. Information about “services,” “covered services,” “providers,” and “network providers”

Services are health care, long-term services and supports, supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services.

Covered services are any of these services that our plan pays for. Covered health care, behavioral health, and long-term services and supports (LTSS) are listed in the Benefits Chart in Chapter 4, Section D, page 66.

Providers are doctors, nurses, and other people who give you services and care. The term providers also includes 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 the health plan. These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long-term services and supports (LTSS) covered by the plan

SCFHP Cal MediConnect covers all services covered by Medicare and Medi-Cal. This includes behavioral health and long-term services and supports (LTSS).

SCFHP Cal MediConnect will generally pay for the health care services, behavioral health services, and LTSS you get if you follow the plan's rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D, page 66 of this handbook).
- The care must be determined **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your 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.
- For medical services, you must have a network provider who has ordered the care. As a plan member, you must choose a network provider to be your **primary care provider (PCP)**.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- In some cases, your PCP must direct you to other providers in the plan's network before you can see those other providers. This is called a **referral**. If you don't get a referral, SCFHP Cal MediConnect may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. To learn more about referrals, see page 49.
- You do not need a referral from your PCP for emergency care or urgently needed care or to see a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, see page 49.
- To learn more about choosing a PCP, see page 48.
- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
 - The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what emergency or urgently needed care means, see Section H, page 54.
 - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. In some cases, our plan must give you approval before you can get certain services. This is called a **prior authorization**. Additionally, you must obtain authorization from SCFHP prior to seeking care outside of the SCFHP Cal MediConnect network. In this situation, we will cover the care at no cost to you. To learn about getting approval to see an out-of-network provider, see Section D, page 51. To learn more about which services need prior authorization, see the Benefits Chart in Chapter 4, Section D, page 66.
 - The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
 - When you first join the plan, you can ask to continue to see your current providers. With some exceptions, we are required to approve this request if we can establish that you had an existing relationship with the providers (see Chapter 1, Section F, page 11). If we approve your request, you can continue seeing the providers you see now for up to 12 months for services. During that time, your case manager will contact you to help you find providers in our network. After 12 months, we will no longer cover your care if you continue to see providers that are not in our network.
 - Continuity of care may be provided for services you are currently getting from a doctor. If you receive services from an ancillary provider (such as durable

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



medical equipment, medical supplies or incontinence supplies for either Medicare or Medi-Cal), SCFHP may transition you to a network provider.

C. Information about your case manager

C1. What a case manager is

A case manager is a clinician or other trained person who works for our plan to provide care coordination services for you, especially during care transitions and hospital discharges.

C2. How you can contact your case manager

You may contact Case Management by calling 1-877-590-8999 (TTY: 711), Monday to Friday, 8:30 a.m. to 5 p.m.

C3. How you can change your case manager

To request to change your case manager, contact Case Management at 1-877-590-8999, Monday through Friday, 8:30 a.m. to 5:00 p.m.

D. Care from primary care providers, specialists, other network medical providers, and out-of-network medical providers

D1. Care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

Definition of a “PCP,” and what a PCP does do for you

Your PCP is the provider who takes care of you and is the first person you see when you need care, unless it is an emergency. You will get your routine or basic care from your PCP. Your PCP will coordinate the rest of the covered services you get from SCFHP Cal MediConnect, including:

- X-rays
- laboratory tests
- therapies
- care from doctors who are specialists



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- hospital admissions
- follow-up care

In some cases, your PCP may need to get prior authorization (prior approval) from SCFHP for certain services.

You may choose a PCP who is a:

- Family Practice Physician (usually treats all ages)
- Obstetrician/Gynecologist (OB/GYN) (treats women) who also does primary care
- General Internal Medicine Physician (treats adults)
- Clinic, including a Federally Qualified Health Center (FQHC), Community Clinic or an Indian Health Service facility in Santa Clara County

You may be able to have a specialist act as your PCP. A specialist is a doctor who provides health care services for a specific disease or part of the body. You may choose a specialist as your PCP if that doctor is listed as a PCP in the *Provider and Pharmacy Directory*.

You may receive care from a nurse practitioner (NP), physician assistant (PA) or certified nurse midwife (CNM) to provide your PCP services. The NP, PA or CNM must work in your PCP's office and be supervised by your PCP. If you are pregnant or you are planning to become pregnant, you also have the right to select an out-of-plan certified nurse midwife (CNM).

Your choice of PCP

You can choose any PCP who is in our network and accepting new members. Refer to the SCFHP "Find a Doctor" search tool or the SCFHP Cal MediConnect *Provider and Pharmacy Directory* on www.scfhp.com for a list of providers in the SCFHP network. When choosing a PCP, you may want to choose a provider:

- that you use now, **or**
- who has been recommended by someone you trust, **or**
- who speaks your language, **or**
- whose offices are easy for you to get to.

If you would like additional information about a provider, such as where they completed their residency, please contact Customer Service. Customer Service can give you the most up-to-date information about our network providers.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



You can also get more information about a provider here:

- Medical school attended and other professional qualifications – visit the California Department of Consumer Affairs (DCA) BreEZe Online Services at www.breeze.ca.gov/datamart/loginCADCA.do.
- Board certification – visit American Board of Medical Specialties Certification Matters at www.certificationmatters.org.

To choose a PCP, sign up for the mySCFHP member portal at www.member.scfhp.com. If you do not select a PCP, SCFHP will choose one for you and notify you. If you need help selecting a PCP, call Customer Service and a Customer Service representative will assist you.

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 plan network, we can help you find a new PCP who is within our plan network.

If we can make the PCP change you want, the change will, in most cases, be effective the first day of the next month. For example, if you ask us to change your PCP in February, in most cases, you will be able to visit your new PCP on March 1.

Services you can get without first getting approval from your PCP

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

- 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 network providers (for example, when you are outside the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are outside the plan's service area. (Please call Customer Service before you leave the service area. We can help you get dialysis while you are away.)
- Flu shots, 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.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- Additionally, if you are eligible to get services from Indian health providers, you may see these providers without a referral.

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. Here are a few examples:

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

Your PCP may send you to specialists or other health care providers if you need services your PCP cannot provide. For some types of services or prescription drugs or to see an out-of-network provider, your PCP, specialist, or other provider may need to get approval in advance from SCFHP. This is called getting **prior authorization**. Please see Chapter 4 for more information on which services require prior authorization.

If the specialist wants you to come back for more care, check first to be sure the prior authorization you get for the first visit covers more visits to the specialist.

D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will 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 will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

SCFHP can help you continue to get care or complete your care for a certain period of time with your current PCP. These special arrangements apply for any of the medical conditions below:

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- An acute condition;
- A serious chronic condition;
- A surgery or other medical procedure;
- A pregnancy, including post-partum care; or
- A terminal illness.

You must tell SCFHP that you want the provider to continue to provide and complete the services. If the provider and SCFHP cannot agree on payment or other terms for providing care, then SCFHP does not have to pay for the services. In this case, if you still want the services, then you will be responsible for paying the provider.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Call SCFHP Cal MediConnect Customer Service at 1-877-723-4795 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

D4. How to get care from out-of-network providers

If medically necessary specialized services are not available from a provider in the SCFHP Cal MediConnect network, you may get these services from an out-of-network provider. Your PCP is responsible for submitting the request for prior authorization for out-of-network services.

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

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

E. How to get long-term services and supports (LTSS)

Long-term services and supports (LTSS) consist of Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), and Nursing Facilities (NF). The services may occur in your home, community, or in a facility. The different types of LTSS are described below:

- **Community-Based Adult Services (CBAS):** Outpatient, facility based service program that delivers skilled nursing care, social services, occupational and



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speech therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services if you meet applicable eligibility criteria.

- **Multipurpose Senior Services Program (MSSP):** A California-specific program that provides Home and Community-Based Services (HCBS) to frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.
 - Medi-Cal eligible individuals who are 65 years or older with disabilities can qualify for this program. This program is an alternative to nursing facility placement.
 - MSSP services may include but not be limited to: Adult Day Care/ Support Center, housing assistance such as physical adaptations and assistive devices, chore and personal care assistance, protective supervision, care management, and other type of services.
- **Nursing Facility (NF):** A facility that provides care for people who cannot safely live at home but who do not need to be in the hospital.

Your case manager will help you understand each program. To find out more about any of these programs, contact SCFHP Cal MediConnect Case Management, at 1-877-590-8999 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m.

F. How to get behavioral health (mental health and substance use disorder) services

You will have access to medically necessary behavioral health services that are covered by Medicare and Medi-Cal. SCFHP Cal MediConnect provides access to behavioral health services covered by Medicare. Medi-Cal covered behavioral health services are not provided by SCFHP Cal MediConnect, but will be available to eligible SCFHP Cal MediConnect members through the Santa Clara County Behavioral Health Services Department.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



F1. What Medi-Cal behavioral health services are provided outside of SCFHP Cal MediConnect through the Santa Clara County Behavioral Health Services Department

Medi-Cal specialty mental health services are available to you through the county mental health plan (MHP) if you meet Medi-Cal specialty mental health services medical necessity criteria. Medi-Cal specialty mental health services provided by the Santa Clara County Behavioral Health Services Department include:

- Mental health services (assessment, therapy, rehabilitation, collateral, and plan development)
- Medication support services
- Day treatment intensive
- Day rehabilitation
- Crisis intervention
- Crisis stabilization
- Adult residential treatment services
- Crisis residential treatment services
- Psychiatric health facility services
- Psychiatric inpatient hospital services
- Targeted case management

Drug Medi-Cal services are available to you through the Santa Clara County Department of Alcohol and Drug Services if you meet the Drug Medi-Cal medical necessity criteria. Drug Medi-Cal services provided by Santa Clara County Department of Alcohol and Drug Services include:

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

In addition to the Drug Medi-Cal services listed above, you may have access to voluntary inpatient detoxification services if you meet the medical necessity criteria.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

There is no prior authorization required for behavioral health services. If you meet medical necessity criteria for specialty mental health services with Santa Clara County Behavioral Health Services Department and/or for Drug Medi-Cal services with Santa Clara County Department of Alcohol and Drug Services, SCFHP Cal MediConnect will link and coordinate your care with the appropriate agency. To access Santa Clara County Drug and Alcohol Services (DADS) directly, call the Gateway intake at 1-800-488-9919.

G. How to get transportation services

Non-emergency medical transportation (NEMT) requires the completion of a physician certification statement (PCS) form to determine the appropriate level of service. This form must be completed by your treating physician prior to the services being arranged or provided. NEMT must be pre-approved by SCFHP Cal MediConnect and arranged at least 5 business days before your scheduled appointment.

Non-medical transportation (NMT) requires you to provide an attestation in person, electronically, or over the telephone that you do not have other transportation resources. NMT must be pre-approved by SCFHP Cal MediConnect and arranged at least 3 business days before your scheduled appointment.

To arrange for NEMT or NMT, login to the mySCFHP member portal or call SCFHP Cal MediConnect Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

H. How to get covered services when you have a medical emergency or urgent need for care, or during a disaster

H1. Care when you have a medical emergency

Definition of 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 does not 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**

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- 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.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Notify SCFHP of your emergency at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. You can also find contact information on the back of your SCFHP Cal MediConnect Member ID Card.

Covered services in a medical emergency

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, Section D, page 77.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by us. 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 might go in for emergency care and have the doctor say it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was not an emergency, we will cover your additional care only if:



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You go to a network provider, **or**
- The additional care you get is considered “urgently needed care” and you follow the rules for getting this care. (See the next section.)

H2. Urgently needed care

Definition of urgently needed care

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care only if:

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

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

If you think you have an urgent medical problem, call the Nurse Advice Line at 1-844-803-6962 (TTY: 711), 24 hours a day, 7 days a week. Nurse Advice can tell you how and where to get care.

Urgently needed care when you are outside the plan's service area

When you are outside the plan's service area, you might not be able to get care from a network provider. In that case, our plan will cover 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 and its territories.

H3. 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 SCFHP Cal MediConnect.

Please visit our website for information on how to obtain needed care during a declared disaster: www.scfhp.com.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section A, page 120 for more information.

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

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

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

If you have paid for your covered services, or if you have gotten a bill for covered medical services, see Chapter 7, page 147 to learn what to do.

11. What to do if services are not covered by our plan

SCFHP Cal MediConnect covers all services:

- That are determined medically necessary, **and**
- That are listed in the plan's Benefits Chart (see Chapter 4, Section D, beginning on page 66), **and**
- That you get by following plan rules.

If you get services that are not covered by our plan, **you must pay the full cost yourself.**

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

Chapter 9, page 165 explains what to do if you want us to cover a medical item or service. It also tells you how to appeal our coverage decision. You may also call Customer Service to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Customer Service to find out what the limits are and how close you are to reaching them.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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

J1. Definition of clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

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

You do need to tell us before you start participating in a clinical research study.

If you plan to be in a clinical research study, you or your case manager should contact Customer Service to let us know you will be in a clinical trial.

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

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay 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 are covered for most items and services 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 are part of a study that Medicare has **not approved**, you will have to pay any costs for being in the study.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



J3. Learning more about clinical research studies

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

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

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

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

You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

K2. Getting 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, the following applies:
 - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You must get approval from us before you are admitted to the facility or your stay will not be covered.

Medicare Inpatient Hospital coverage limits apply. See the Benefits Chart in Chapter 4, Section D, beginning on page 66.

L. Durable Medical Equipment (DME)

L1. DME as a member of our plan

DME means certain items ordered by a provider 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, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of SCFHP Cal MediConnect, you usually will not own DME, no matter how long you rent it.

In certain situations, we will transfer ownership of the DME item to you. This will be determined at the time of the authorization, and based on whether it is medically necessary to own the DME. In certain situations, such as customized wheelchairs or splints, SCFHP Cal MediConnect will transfer ownership of the DME item. Call Customer Service to find out about the requirements you must meet and the papers you need to provide.

L2. DME ownership when you switch to Original Medicare or Medicare Advantage

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

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2021/2020* Handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

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

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

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

L3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- 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.

L4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will 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 the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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 will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services SCFHP Cal MediConnect 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 the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

A. Your covered services

This chapter tells you what services SCFHP Cal MediConnect pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, page 117. 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 the plan's rules. See Chapter 3, Section B, page 45 for details about the plan's rules.

If you need help understanding what services are covered, call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

B. Rules against providers charging you for services

We do not allow SCFHP Cal MediConnect 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, see Chapter 7, Section A, page 147 or call Customer Service.

C. Our plan's Benefit Chart

The Benefits Chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services.

We will pay for the services listed in the Benefits Chart only 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 coverage requirements described below.

- Your Medicare and Medi-Cal covered services must be provided 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 means you need the services 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 alleviate severe pain.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- You get your care from a network provider. A network provider is a provider who works with us. In most cases, we will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 47 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 see someone that is not your PCP or use other providers in the plan's network. This is called a referral. Chapter 3, Section B, page 49 has more information about getting a referral and explains when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization. Covered services that need prior authorization first are marked in the Benefits Chart by a footnote. In addition, you must get prior authorization first for the following services that are not listed in the benefits chart:
 - Incontinence cream and diapers,
 - Abdominoplasty,
 - Bariatric procedure,
 - Blepharoplasty,
 - Breast reductions and augmentation,
 - Cochlear auditory implant,
 - Dental surgery,
 - Dermatology procedures (laser treatment, skin injections and implants),
 - Experimental/investigational procedures/services and new technologies,
 - Nasal and sinus surgery,
 - Rhinoplasty,
 - Septoplasty,
 - Neuro and spinal cord stimulator,
 - Orthognathic procedures (including TMJ treatment),
 - Panniculectomy,
 - Plastic surgery reconstructive procedures,
 - Spinal surgery,
 - Stereotactic radiosurgery and stereotactic body radiotherapy
 - Surgery for obstructive sleep apnea,
 - Varicose vein treatment,
 - Cardiac and pulmonary rehabilitation,
 - Genetic testing and counseling,
 - Hyperbaric oxygen therapy,
 - Transplant-related services (except cornea transplant) prior to evaluation,
 - Transgender services.



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- All preventive services are free. You will see this apple 🍏 next to preventive services in the Benefits Chart.
- Care Plan Optional (CPO) services may be available under your Individualized Care Plan. These services give you more help at home, like meals, help for you or your caregiver, or shower grab bars and ramps. These services can help you live more independently but do **not** replace long-term services and supports (LTSS) that you are authorized to get under Medi-Cal. Examples of CPO services that SCFHP Cal MediConnect has offered in the past include: interim personal care and pest removal. If you need help or would like to find out how CPO services may help you, contact your case manager.

D. The Benefits Chart

Services that our plan pays for	What you must pay
<p>🍏 Abdominal aortic aneurysm screening</p> <p>We will pay for a one-time ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p>Acupuncture</p> <p>We will pay for up to 2 outpatient services per month in any one calendar year, or more often if they are medically necessary.</p> <p>Not reimbursable when billed as an emergency or inpatient service. Must be used to treat a condition also covered by other modalities. Covered when provided by physician, dentist, podiatrist, and acupuncturist.</p> <p>This is a non-opioid pain management alternative.</p> <p>We will 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"> • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; and • not associated with pregnancy. <p>In addition, we will 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>Note: Prior authorization may be required for more than 2 services per month, pregnant women, or members living in a nursing facility.</p>	<p>\$0</p>






If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Services that our plan pays for	What you must pay
<p> Alcohol misuse screening and counseling</p> <p>We will pay for one alcohol-misuse screening (SBIRT) 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>	<p>\$0</p>
<p>Ambulance services</p> <p>Covered ambulance services include ground, fixed-wing, and rotary-wing 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>\$0</p>
<p> Annual wellness visit</p> <p>You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We will pay for this once every 12 months.</p>	<p>\$0</p>
<p> Bone mass measurement</p> <p>We will 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 will pay for the services once every 24 months, or more often if they are medically necessary. We will also pay for a doctor to look at and comment on the results.</p>	<p>\$0</p>


If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Services that our plan pays for	What you must pay
<p> Breast cancer screening (mammograms)</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	\$0
<p>Cardiac (heart) rehabilitation services</p> <p>We will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor’s order.</p> <p>We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.</p> <p>Note: Prior authorization may be required.</p>	\$0
<p> Cardiovascular (heart) disease risk reduction visit (therapy for heart disease)</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 visits, your doctor may:</p> <ul style="list-style-type: none"> • Discuss aspirin use, • Check your blood pressure, and/or • Give you tips to make sure you are eating well. 	\$0
<p> Cardiovascular (heart) disease testing</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




If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Services that our plan pays for	What you must pay
<p> Cervical and vaginal cancer screening</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • 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 • For women aged 30-65: human papillomavirus (HPV) testing or Pap plus HPV testing once every 5 years 	<p>\$0</p>
<p>Chiropractic services</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Adjustments of the spine to correct alignment (when accompanied by documented subluxation) • Up to 2 outpatient chiropractic services in any one calendar month, or more often if medically necessary • Note: Prior authorization may be required for more than 2 services per month. <p>This is a non-opioid pain management alternative.</p>	<p>\$0</p>



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Services that our plan pays for	What you must pay
<p> Colorectal cancer screening</p> <p>For people 50 and older (and younger than 50 if you have a strong family history), we will pay for the following services:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test <i>or</i> fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years • Colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy) • Colonoscopy (or screening barium enema) for people at high risk of colorectal cancer, every 24 months 	<p>\$0</p>
<p>Community-Based Adult Services (CBAS)</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 will pay for CBAS if you meet the eligibility criteria.</p> <p>Note: If a CBAS facility is not available, we can provide these services separately.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p> Counseling to stop smoking or tobacco use</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"> We will 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 counseling face-to-face visits. <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"> We will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. <p>If you are pregnant, you may get unlimited tobacco cessation counseling.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p>Dental services</p> <p>Certain dental services, including cleanings, fillings, and dentures, are available through the Medi-Cal Dental Program. See Section E, page 113 for more information.</p>	<p>\$0</p>
<p> Depression screening</p> <p>We will 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>	<p>\$0</p>


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Services that our plan pays for	What you must pay
<p> Diabetes screening</p> <p>We will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors:</p> <ul style="list-style-type: none"> • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) <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
<p> Diabetic self-management training, services, and supplies</p> <p>We will pay for the following services for all people who have diabetes (whether they use insulin or not):</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose, including the following: <ul style="list-style-type: none"> ○ A blood glucose monitor ○ Blood glucose test strips ○ Lancet devices and lancets ○ Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, we will pay for the following: <ul style="list-style-type: none"> ○ One pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, or ○ 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) • We will pay for training to help you manage your diabetes, in some cases. To find out more, contact Customer Service. <p>See page 60 for more information on durable medical equipment (DME) and related supplies.</p> <p>Note: Prior authorization may be required for DME supplies or items.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “Durable medical equipment (DME),” see Chapter 12, page 249 of this handbook.)</p> <p>The following items are covered:</p> <ul style="list-style-type: none"> • Wheelchairs • Crutches • Powered mattress systems • Dry pressure pad for mattress • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps and pole • Enteral pump and supplies • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers • Standard curved handle or quad cane and replacement supplies • Cervical traction (over the door) • Bone stimulator • Dialysis care equipment <p>Other items may be covered.</p> <p style="text-align: center;">This benefit is continued on the next page</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Durable medical equipment (DME) and related supplies (continued)</p> <p>With this <i>Member Handbook</i>, we sent you SCFHP’s List of DME. The list tells you the brands and makers of DME that we will pay for. This most recent list of brands, makers, and suppliers is available on our website at www.scfhp.com.</p> <p>Generally, SCFHP covers any DME covered by Medicare and Medi-Cal from the brands and makers on this list. We will not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to SCFHP Cal MediConnect and are using a brand of DME that is not on our list, we will continue to pay for this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically right for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)</p> <p>If you (or your doctor) do not agree with the plan’s coverage decision, you or your doctor may file an appeal. You can also file an appeal if you do not agree with your doctor’s decision about what product or brand is right for your medical condition. (For more information about appeals, see Chapter 9, Section D, page 170.)</p> <p>Note: Prior authorization may be required for DME.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Emergency care</p> <p>Emergency care means services that are:</p> <ul style="list-style-type: none"> • Given by a provider trained to give emergency services, and • Needed to treat a medical emergency. <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"> • 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: <ul style="list-style-type: none"> ○ 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. <p>Emergency/urgent care is not covered outside the U.S. and its territories.</p>	<p style="text-align: center;">\$0</p> <p>If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay.</p>



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Services that our plan pays for	What you must pay
<p>Family planning services</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 will pay for the following services:</p> <ul style="list-style-type: none"> • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (IUD, implants, injections, birth control pills, patch, or ring) • Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • Counseling and diagnosis of infertility and related services • Counseling, testing, and treatment for sexually transmitted infections (STIs) • Counseling and testing for HIV and AIDS, and other HIV-related conditions • 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.) • Genetic counseling <p>We will also pay for some other family planning services. However, you must see a provider in our provider network for the following services:</p> <ul style="list-style-type: none"> • Treatment for medical conditions that may cause infertility (This service does not include artificial ways to become pregnant.) 	<p style="text-align: center;">\$0</p>


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Services that our plan pays for	What you must pay
<p>Fitness Benefit</p> <p>A fitness benefit is offered to SCFHP Cal MediConnect members to encourage an active lifestyle and improve their quality of life. Members have choices available at no cost, including:</p> <ul style="list-style-type: none"> • Silver&Fit® Healthy Aging and Exercise Program: <ul style="list-style-type: none"> ○ The Fitness Center Program: You have access to 16,000+ Silver&Fit® fitness centers or exercise centers across the country.* ○ The Home Fitness Program: If you cannot get to a fitness center or want to work out at home, you can get up to two (2) Home Kits and one (1) Stay Fit Kit per benefit year. ○ The Healthy Aging Coaching Program: You can access weekly one-on-one Silver&Fit Aging Coaching sessions <p>*Non-standard services that call for an added fee are not part of the Silver&Fit program and will not be reimbursed.</p> <ul style="list-style-type: none"> • Silver&Fit® members also have access to numerous resource to keep you active from anywhere, including 48 Healthy Aging classes (online or DVD); daily workout classes on Facebook Live and YouTube, 2,000+ digital workout classes on the Silver&Fit ASHConnect™ mobile app, and rewards for reaching new milestones. <p>This is a non-opioid pain management alternative. Talk to your doctor before you start or change your exercise routine.</p> <p>The SCFHP fitness benefit may also be available from other providers. For more information, call SCFHP Cal MediConnect Customer Service.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p> Health and wellness education programs</p> <p>We offer many programs that focus on certain health conditions. These include:</p> <ul style="list-style-type: none"> • Health Education classes; • Nutrition Education classes; • Smoking and Tobacco Use Cessation; and • Nursing Hotline <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p>Hearing services</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>Hearing aid benefits are subject to a \$1,510 maximum allowance per member for both ears combined per fiscal year (July 1 – June 30), and includes molds, modifications supplies, and accessories.</p> <p>If you are pregnant or reside in a nursing facility, we will also pay for hearing aids, including:</p> <ul style="list-style-type: none"> • Molds, supplies, and inserts • Repairs that cost more than \$25 per repair • An initial set of batteries • Six visits for training, adjustments, and fitting with the same vendor after you get the hearing aid • Trial period rental of hearing aids <p>Note: Prior authorization may be required for nursing facility residents.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p> HIV screening</p> <p>We pay for one HIV screening exam every 12 months for people who:</p> <ul style="list-style-type: none"> • Ask for an HIV screening test, or • Are at increased risk for HIV infection. <p>For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.</p>	<p>\$0</p>
<p>Home health agency care</p> <p>Before you can get home health services, a doctor must tell us you need the services, and they must be provided by a home health agency.</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • 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.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies <p>Note: Prior authorization may be required.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Home infusion therapy</p> <p>The plan will pay 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"> • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; and • Supplies, such as tubing or a catheter. <p>The plan will cover home infusion services that include but are not limited to:</p> <ul style="list-style-type: none"> • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; and • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. <p>Note: Prior authorization may be required.</p>	<p>\$0</p>


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Services that our plan pays for	What you must pay
<p>Hospice care</p> <p>You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>The plan will pay for the following while you are getting hospice services:</p> <ul style="list-style-type: none"> • Drugs to treat symptoms and pain • Short-term respite care • Home care <p>Hospice services and services covered by Medicare Part A or B are billed to Medicare.</p> <ul style="list-style-type: none"> • See Section E, page 114 of this chapter for more information. <p>For services covered by SCFHP Cal MediConnect but not covered by Medicare Part A or B:</p> <ul style="list-style-type: none"> • SCFHP Cal MediConnect will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal prognosis. You pay nothing for these services. <p>For drugs that may be covered by the SCFHP Cal MediConnect Medicare Part D benefit:</p> <ul style="list-style-type: none"> • Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section F, page 131. <p>Note: If you need non-hospice care, you should call your case manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis.</p>	<p style="text-align: center;">\$0</p>



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Services that our plan pays for	What you must pay
<p> Immunizations</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, page 135 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>NOTE: Prior authorization may be required for Part B drugs.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Inpatient hospital care</p> <p>We will pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance abuse services <p style="text-align: right;">This benefit is continued on the next page</p>	<p style="text-align: center;">\$0</p> <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>



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Services that our plan pays for	What you must pay
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> In some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. <p>If you need a transplant, a Medicare-approved transplant center will review your case and decide whether 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 SCFHP provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange and pay for lodging and travel costs for you and one other person.</p> <ul style="list-style-type: none"> Blood, including storage and administration Physician services <p>Note: Prior authorization may be required.</p>	<p>\$0</p> <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>

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



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Services that our plan pays for	What you must pay
<p>Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay</p> <p>If your inpatient stay is not reasonable and medically necessary, we will not pay for it.</p> <p>However, in certain situations where inpatient care is not covered, we may still pay for services you get while you are in a hospital or nursing facility. To find out more, contact Customer Service.</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Doctor services • Diagnostic tests, like lab tests • X-ray, radium, and isotope therapy, including technician materials and services • Surgical dressings • Splints, casts, and other devices used for fractures and dislocations • Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: <ul style="list-style-type: none"> ○ Replace all or part of an internal body organ (including contiguous tissue), or ○ Replace all or part of the function of an inoperative or malfunctioning internal body organ. • 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 the patient's condition • Physical therapy, speech therapy, and occupational therapy <p>Note: Prior authorization may be required.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Kidney disease services and supplies</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease. We will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 45. • Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • 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. <p>Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see “Medicare Part B prescription drugs” in this chart.</p> <p>Note: Prior authorization may be required for treatment or supplies.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p> Lung Cancer Screening</p> <p>The plan will pay for lung cancer screening every 12 months if you:</p> <ul style="list-style-type: none"> • Are aged 55-80, and • Have a counseling and shared decision-making visit with your doctor or other qualified provider, and • Have smoked at least 1 pack a day for 30 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years. <p>After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.</p>	<p>\$0</p>
<p> Medical nutrition therapy</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 will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We may approve additional services if medically necessary.</p> <p>We will 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 your treatment is needed in the next calendar year. We may approve additional services if medically necessary.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in:</p> <ul style="list-style-type: none"> • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle. 	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Medicare. SCFHP Cal MediConnect will pay for the following drugs:</p> <ul style="list-style-type: none"> • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Retacrit®, Epogen®, Procrit®, or Aranesp®) • IV immune globulin for the home treatment of primary immune deficiency diseases <p style="text-align: right;">This benefit is continued on the next page</p>	<p style="text-align: center;">\$0</p>

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Services that our plan pays for	What you must pay
<p>Medicare Part B prescription drugs (continued)</p> <p>The following link will take you to a list of Part B drugs that may be subject to step therapy: www.scfhp.com/healthcareplans/calmediconnect/member-materials</p> <p>We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit.</p> <p>Chapter 5, page 117 explains the outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered.</p> <p>Chapter 6, page 135 explains what you pay for your outpatient prescription drugs through our plan.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Services that our plan pays for	What you must pay
<p>Multipurpose Senior Services Program (MSSP)</p> <p>MSSP is a case management program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals.</p> <p>To be eligible, you must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility.</p> <p>MSSP services include:</p> <ul style="list-style-type: none"> • Adult Day Care / Support Center • Housing Assistance • Chore and Personal Care Assistance • Protective Supervision • Care Management • Respite • Transportation • Meal Services • Social Services • Communications Services <p>This benefit is covered up to \$5,356.25 per year.</p> <p>Note: Prior authorization is required from MSSP.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Non-emergency medical transportation</p> <p>This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.</p> <p>The forms of transportation are authorized when:</p> <ul style="list-style-type: none"> • 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, and • Transportation is required for the purpose of obtaining needed medical care. <p>Depending on the service, prior authorization may be required.</p> <p>Non-emergency medical transportation (NEMT) requires the completion of a physician certification statement (PCS) form to determine the appropriate level of service. This form must be completed by your treating physician prior to the services being arranged or provided.</p> <p>NEMT must be pre-approved by SCFHP Cal MediConnect and arranged at least 5 business days before your scheduled appointment. Please login to the mySCFHP member portal at www.member.scfhp.com or call SCFHP Cal MediConnect Customer Service to arrange transportation.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Non-medical transportation</p> <p>This benefit allows for transportation to health-related locations by passenger car, taxi, or other forms of public/private transportation.</p> <p>This benefit does not limit your non-emergency medical transportation benefit.</p> <p>Non-medical transportation (NMT) requires you to provide an attestation in person, electronically or over the phone that you do not have other transportation resources.</p> <p>NMT must be pre-approved by SCFHP Cal MediConnect and arranged at least 3 business days before your scheduled appointment. Please login to the mySCFHP member portal at www.member.scfhp.com or call SCFHP Cal MediConnect Customer Service to arrange transportation.</p>	<p>\$0</p>


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Services that our plan pays for	What you must pay
<p>Nursing facility care</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 will pay for include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if it is medically necessary) • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Respiratory therapy • 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.) • Blood, including storage and administration • Medical and surgical supplies usually given by nursing facilities • Lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • Use of appliances, such as wheelchairs usually given by nursing facilities • Physician/practitioner services • Durable medical equipment • Dental services, including dentures • Vision benefits • Hearing exams and hearing aids <p style="text-align: center;">This benefit is continued on the next page</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Nursing facility care (continued)</p> <ul style="list-style-type: none"> • Chiropractic care • Podiatry services <p>You will 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"> • 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). • A nursing facility where your spouse is living at the time you leave the hospital. <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p> Obesity screening and therapy to keep weight down</p> <p>If you have a body mass index of 30 or more, we will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Opioid treatment program services</p> <p>The plan will pay for the following services to treat opioid use disorder:</p> <ul style="list-style-type: none"> • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>We will pay for the following services and other medically necessary services not listed here:</p> <ul style="list-style-type: none"> • X-rays, MRI, and PET scan • Radiation (radium and isotope) therapy and chemotherapy, including technician materials and supplies • Medical supplies, such as wound care dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, including storage and administration. You should talk to your doctor and get a referral. • Other outpatient diagnostic tests <p>Note: Prior authorization may be required.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Outpatient hospital services</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"> • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services <ul style="list-style-type: none"> ○ Observation services help your doctor know if you need to be admitted to the hospital as an “inpatient.” ○ Sometimes you can be in the hospital overnight and still be an “outpatient.” ○ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can’t give yourself <p>Note: Prior authorization may be required.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Outpatient mental health care</p> <p>We will pay for mental health services provided by:</p> <ul style="list-style-type: none"> • A state-licensed psychiatrist or doctor • A clinical psychologist • A clinical social worker • A clinical nurse specialist • A nurse practitioner • A physician assistant • Any other Medicare-qualified mental health care professional as allowed under applicable state laws <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Clinic services • Day treatment • Psychosocial rehab services • Partial hospitalization/Intensive outpatient programs • Individual and group mental health evaluation and treatment • Psychological testing when clinically indicated to evaluate a mental health outcome • Outpatient services for the purposes of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Psychiatric consultation <p>Note: Prior authorization may be required.</p>	<p>\$0</p>



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Services that our plan pays for	What you must pay
<p>Outpatient rehabilitation services</p> <p>We will 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>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p>Outpatient substance abuse services</p> <p>We will pay for the following services, and maybe other services not listed here:</p> <ul style="list-style-type: none"> • Alcohol misuse screening and counseling • Treatment of drug abuse • Group or individual counseling by a qualified clinician • Subacute detoxification in a residential addiction program • Alcohol and/or drug services in an intensive outpatient treatment center • Extended release Naltrexone (vivitrol) treatment 	<p>\$0</p>
<p>Outpatient surgery</p> <p>We will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Partial hospitalization services</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>Note: Prior authorization may be required.</p>	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Medically necessary health care or surgery services given in places such as: <ul style="list-style-type: none"> ○ Physician’s office ○ Certified ambulatory surgical center ○ Hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider, if your doctor orders it to see whether you need treatment • 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 the member’s home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: <ul style="list-style-type: none"> ○ you’re not a new patient and ○ the check-in isn’t related to an office visit in the past 7 days and ○ the check-in doesn’t lead to an office visit within 24 hours or the soonest available appointment <p style="text-align: center;">This benefit is continued on the next page</p>	<p style="text-align: center;">\$0</p>

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Services that our plan pays for	What you must pay
<p>Physician/provider services, including doctor’s office visits (continued)</p> <ul style="list-style-type: none"> • Second opinion by another network provider before a medical procedure surgery • Non-routine dental care. Covered services are limited to: <ul style="list-style-type: none"> ○ Surgery of the jaw or related structures ○ Setting fractures of the jaw or facial bones ○ Pulling teeth before radiation treatments of neoplastic cancer ○ Services that would be covered when provided by a physician 	<p>\$0</p>
<p>Podiatry services</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes <p>Note: Prior authorization may be required for nursing facility residents.</p>	<p>\$0</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, we will pay for the following services once every 12 months:</p> <ul style="list-style-type: none"> • A digital rectal exam • A prostate specific antigen (PSA) test 	<p>\$0</p>




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Services that our plan pays for	What you must pay
<p>Prosthetic devices and related supplies</p> <p>Prosthetic devices replace all or part of a body part or function. We will pay for the following prosthetic devices, and maybe other devices not listed here:</p> <ul style="list-style-type: none"> • Colostomy bags and supplies related to colostomy care • Enteral and parenteral nutrition, including feeding supply kits, infusion pump, tubing and adaptor, solutions, and supplies for self-administered injections • Pacemakers • Braces • Prosthetic shoes • Artificial arms and legs • Breast prostheses (including a surgical brassiere after a mastectomy) • Prostheses to replace all of part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect • Incontinence cream and diapers <p>We will also pay for some supplies related to prosthetic devices. We will also pay to repair or replace prosthetic devices.</p> <p>We offer some coverage after cataract removal or cataract surgery. See “Vision care” later in this section on page 111 for details.</p> <p>We will not pay for prosthetic dental devices.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>

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Services that our plan pays for	What you must pay
<p>Pulmonary rehabilitation services</p> <p>We will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.</p> <p>We will pay for respiratory services for ventilator-dependent patients.</p> <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p> Sexually transmitted infections (STIs) screening and counseling</p> <p>We will 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 will 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 will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.</p>	<p>\$0</p>



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

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Services that our plan pays for	What you must pay
<p>Skilled nursing facility (SNF) care (continued)</p> <p>You will 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"> • 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) • A nursing facility where your spouse lives at the time you leave the hospital <p>Note: Prior authorization may be required.</p>	<p>\$0</p>
<p>Supervised Exercise Therapy (SET)</p> <p>The plan will pay for SET for members with symptomatic peripheral artery disease (PAD) who have a referral for PAD from the physician responsible for PAD treatment. The plan will pay for:</p> <ul style="list-style-type: none"> • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider <p>The SET program must be:</p> <ul style="list-style-type: none"> • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques 	<p>\$0</p>




If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Services that our plan pays for	What you must pay
<p>Urgent care</p> <p>Urgent care is care given to treat:</p> <ul style="list-style-type: none"> • A non-emergency that requires immediate medical care, or • A sudden medical illness, or • An injury, or • A condition that needs care right away. <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 cannot get to a network provider.</p> <p>This coverage is within the United States and its territories.</p>	<p>\$0</p>


If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Services that our plan pays for	What you must pay
<p> Vision care</p> <p>We will pay for the following services:</p> <ul style="list-style-type: none"> • One routine eye exam every year (a referral may be required); and • Up to \$200 for eyeglasses (frames and lenses) or up to \$200 for contact lenses every two years. <p>We will 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 will pay for one glaucoma screening each year. People at high risk of glaucoma include:</p> <ul style="list-style-type: none"> • People with a family history of glaucoma • People with diabetes • African-Americans who are age 50 and older • Hispanic Americans who are 65 or older <p>We will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery).</p>	<p>\$0</p>



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Services that our plan pays for	What you must pay
<p> “Welcome to Medicare” Preventive Visit</p> <p>We cover the one-time “Welcome to Medicare” preventive visit. The visit includes:</p> <ul style="list-style-type: none"> • A review of your health, • Education and counseling about the preventive services you need (including screenings and shots), and • Referrals for other care if you need it. <p>Note: 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>

E. Benefits covered outside of SCFHP Cal MediConnect

The following services are not covered by SCFHP Cal MediConnect but are available through Medicare fee-for-service 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 remain 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 receive 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.aspx.

For CCT transition coordination services:

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



For services that are not related to your CCT transition:

The provider will bill SCFHP Cal MediConnect for your services. SCFHP Cal MediConnect will pay for the services provided after your transition. You pay nothing for these services.

While you are getting CCT transition coordination services, SCFHP Cal MediConnect will pay for the services that are listed in the Benefits Chart in Section D of this chapter.

No change in SCFHP Cal MediConnect drug coverage benefit:

Drugs are not covered by the CCT program. You will continue to receive your normal drug benefit through SCFHP. For more information, please see Chapter 5.

Note: If you need non-CCT transition care, you should call your case manager to arrange the services. Call 1-877-590-8999 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m. Non-CCT transition care is care that is not related to your transition from an institution/facility.

E2. Medi-Cal Dental Program

Certain dental services are available through the Medi-Cal Dental Program; for example, services such as:

- Initial examinations, X-rays, cleanings, and fluoride treatments
- Restorations and crowns
- 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, please 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/ 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, please contact Health Care Options at 1-800-430-4263 (TDD users call 1-800-430-7077), Monday through Friday, 8:00 a.m. to 6:00 p.m. The call is free.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

E3. Hospice Care

You can get care from any hospice program certified by Medicare. 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. Your hospice doctor can be a network provider or an out-of-network provider.

See the Benefits Chart in Section D of this chapter for more information about what SCFHP Cal MediConnect pays 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 will bill Medicare for your services. Medicare will pay 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.

For drugs that may be covered by SCFHP's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, page 124.

Note: If you need non-hospice care, you should call your case manager to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call 1-877-590-8999 (TTY: 711), Monday through Friday, 8:30 a.m. to 5:00 p.m. Non-hospice care is care that is not related to your terminal prognosis.

F. Benefits not covered by SCFHP Cal MediConnect, Medicare, or Medi-Cal

This section tells you what kinds of benefits are excluded by the plan. Excluded means that we do not pay for these benefits. Medicare and Medi-Cal will not pay for them either.

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



We will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section E3, page 177.

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

- Services considered not “reasonable and medically necessary,” according to the standards of Medicare and Medi-Cal, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, Section J, page 58 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 it is medically necessary and Medicare pays for it.
- A private room in a hospital, except when it is medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home, except as a limited benefit restricted to those with specific needs as determined by an individualized care plan.
- 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 will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in Section D.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.



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- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Regular hearing exams.
- 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.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 5: Getting your outpatient prescription drugs through the plan

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. Chapter 6, Section C, page 138 tells you what you pay for these drugs. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

SCFHP Cal MediConnect also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some 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, see the Benefits Chart in Chapter 4, page 92.

Rules for the plan's outpatient drug coverage

We will 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. 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. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on the 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.
 - See Chapter 9, Section F3, page 191 to learn about asking for an exception.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain medical references.



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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we will pay for prescriptions **only** if they are filled at any of our network pharmacies. A network pharmacy is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

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

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

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

If you do not have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. You can then ask us to pay you back for our share. If you cannot pay for the drug, contact SCFHP Cal MediConnect Customer Service right away. We will do what we can to help.

- To learn how to ask us to pay you back, see Chapter 7, Section A, page 147.
- If you need help getting a prescription filled, you can contact SCFHP Cal MediConnect Customer Service.

A3. What to do if you change to a different network pharmacy

If you change pharmacies and need a refill of a prescription, 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, you can contact SCFHP Cal MediConnect Customer Service.

A4. What to do if your pharmacy leaves the network

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

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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 are a resident of a long-term care facility, we must 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 any difficulty accessing your drug benefits in a long-term care facility, please contact SCFHP Cal MediConnect Customer Service.
- 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 supply drugs requiring special handling and instructions on their use.

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

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

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

Filling my prescriptions by mail

To get information about filling your prescriptions by mail, call SCFHP Cal MediConnect Customer Service or go to www.scfhp.com/healthcareplans/calmediconnect.

Usually, a mail-order prescription will get to you within 10 calendar days. However, sometimes your mail-order prescription may be delayed. If delivery is delayed, you may contact your provider for an emergency prescription and take the prescription to any network pharmacy. The pharmacy may contact SCFHP Cal MediConnect to get an emergency override due to the delay in the mail-order process.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Mail-order processes

The 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 will automatically fill and deliver new prescriptions it gets from you.

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

After the pharmacy gets a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time.

- This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before you are billed and it is shipped.
- It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 10 calendar days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Call MedImpact Direct Customer Service to update your contact information at 1-855-873-8739, Monday through Friday, 5 a.m. to 5 p.m. and Saturday 6 a.m. to 2 p.m. TTY is users should call 711.

A7. Getting a long-term supply of drugs

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

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 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 SCFHP Cal MediConnect Customer Service for more information.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



For certain kinds of drugs, you can use the plan's network mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

A8. Using a pharmacy that is not in the plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you are not 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.

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

- When filling a specialized drug that is otherwise not available at a network pharmacy
- When filling a drug that has limited distribution
- When filling a drug in an emergency situation when network pharmacies are not available, such as emergency illness while traveling or during a declared disaster

In these cases, please check first with SCFHP Cal MediConnect Customer Service to see if there is a network pharmacy nearby.

A9. Paying you back if you pay for a prescription

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

To learn more about this, see Chapter 7, Section A, page 147.

B. The plan's Drug List

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

The drugs on the Drug List are selected by us with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

B1. Drugs on the Drug List

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under your Medi-Cal benefits.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

The Drug List includes both brand name and generic drugs. Generic drugs have the same active ingredients as brand name drugs. Generally, they work just as well as brand name drugs and usually cost less.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call SCFHP Cal MediConnect Customer Service.

B2. How to find a drug on the Drug List

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at www.scfhp.com. The Drug List on the website is always the most current one.
- Call SCFHP Cal MediConnect Customer Service to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are not on the Drug List

We do not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow us to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

SCFHP Cal MediConnect will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9, Section F3, page 191.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Medi-Cal drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by SCFHP for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration (FDA) or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was

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not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Medi-Cal.

- 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 when the company who makes the drugs says that you have to have tests or services done only by them

B4. Drug List cost-sharing tiers

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

- Tier 1 drugs are generic drugs. The copay is \$0.
- Tier 2 drugs are brand name drugs. The copay is from \$0 to \$9.20, depending on your income (highest cost-sharing tier).
- Tier 3 drugs are non-Medicare prescription drugs that are covered by Medi-Cal. The copay is \$0.
- Tier 4 drugs are non-Medicare over-the-counter (OTC) drugs that are covered by Medi-Cal. The copay is \$0.

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

Chapter 6, Section D3, page 140 tells the amount you pay for drugs in each cost-sharing tier.

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when the plan covers them. In general, 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 will work just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider



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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, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

To learn more about asking for exceptions, see Chapter 9, F3, page 191.

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, our network pharmacies will give you the generic version.

- We usually will not pay for the brand name drug when there is a generic version.
- However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.
- Your copay may be greater for the brand name drug than for the generic drug.

2. Getting plan approval in advance

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

3. Trying a different drug first

In general, we want you to try lower-cost drugs (that often 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, we will then 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 the Drug List. For the most up-to-date information, call SCFHP Cal MediConnect Customer Service or check our website at www.scfhp.com.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



D. Reasons your drug might not be covered

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

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

There are things you can do if your drug is not covered in the way that you would like it to be.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on the Drug List or when it 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 have 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 the plan last year.
 - We will cover a temporary supply of your drug **during the first 90 days of the calendar year.**
 - This temporary supply will be for up to a 31-day supply.
 - If your prescription is written for fewer days we will allow multiple refills to provide up to a maximum of a 31-day supply of medication. You must fill the prescription at a network pharmacy.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- 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 will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan.
 - This temporary supply will be for up to a 31-day supply.
 - If your prescription is written for fewer days we will allow multiple refills to provide up to a maximum of a 31-day supply of medication. You must fill the prescription at a network pharmacy.
 - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in the plan for more than 90 days and live in a long-term care facility and need a supply right away.
 - We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
 - If you are transitioning between different levels of care (for example, into or out of a long-term care facility or a hospital), SCFHP will cover up to a one month supply of drug for you to use in your new setting. This will take care of any restrictions that may exist during this transition period.
 - To ask for a temporary supply of a drug, call Customer Service.

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

- You can change to another drug.

There may be a different drug covered by our plan that works for you. You can call SCFHP Cal MediConnect Customer Service to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

OR

- You can 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 even though it is not on the Drug List. Or you can ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



To learn more about asking for an exception, see Chapter 9, Section F3, page 191.

If you need help asking for an exception, you can contact SCFHP Cal MediConnect Customer Service.

E. Changes in coverage for your drugs

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

- Decide to require or not require prior approval for a drug. (Prior approval is permission from SCFHP Cal MediConnect before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, see Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally 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 the 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 the Drug List changes, you can always:

- Check our up to date Drug List online at www.scfhp.com or
- Call Customer Service to check the current Drug List at 1-877-723-4795.

Some changes to the Drug List will 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 the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same or will be lower.

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



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
- You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please see Chapter 9 of this handbook for more information on exceptions.
- **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 will take it off the Drug List. If you are taking the drug, we will let you know. You should contact your provider to discuss what to do for your medical condition.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the 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 the Drug List **or**
 - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List or
- Let you know and give you a 31-day supply of the drug after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. He or she can help you decide:

- If there is a similar drug on the Drug List you can take instead or
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, see Chapter 9, Section F3, page 191.

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 will 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 will not affect your use of the drug for the rest of the year.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



F. Drug coverage in special cases

F1. If you are in a hospital or a skilled nursing facility for a stay that is covered by our plan

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

To learn more about drug coverage and what you pay, see Chapter 6, Section C, page 138.

F2. If you are in a long-term care facility

Usually, a long-term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living 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, please contact SCFHP Cal MediConnect Customer Service.

F3. If you are in a Medicare-certified hospice program

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

- If you are enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug.
- To prevent delays in getting any unrelated drugs that should be covered by our plan, 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 should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

To learn more about the hospice benefit, see Chapter 4, page 63.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

G. Programs on drug safety and managing drugs

G1. Programs to help members 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 are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or are in a Drug Management Program to help you use your opioid medications safely, 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 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

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them. In addition, you'll get 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. Bring your

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, 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 that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

If you have any questions about these programs, please contact SCFHP Cal MediConnect Customer Service.

G3. Drug management program to help members safely use their opioid medications

SCFHP Cal MediConnect 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 certain doctors**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain 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 will 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 file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, see Chapter 9 Chapter 9, Section E3, page 177.)



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

The DMP may not apply to you if you:

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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

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, **and**
- Drugs and items covered by the plan as additional benefits.

Because you are eligible for Medi-Cal, you are getting “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

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 the *Member Handbook*.

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

- Our List of Covered Drugs.
 - We call this the “Drug List.” It tells you:
 - Which drugs we pay for
 - Which of the four cost-sharing tiers each drug is in
 - Whether there are any limits on the drugs
 - If you need a copy of the Drug List, call SCFHP Cal MediConnect Customer Service. You can also find the Drug List on our website at www.scfhp.com. The Drug List on the website is always the most current.
- Chapter 5 of this *Member Handbook*.
 - Chapter 5, page 117 tells how to get your outpatient prescription drugs through our plan.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- Our Provider and Pharmacy Directory.
 - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with us.
 - The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 120.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



A. The *Explanation of Benefits* (EOB)

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

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- 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 report called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month**. The report 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 the total payments made since January 1.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, see the Drug List.

B. How to keep track of your drug costs

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

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This will help 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 have paid for. You can ask us to pay you back for our share of the cost of the drug.

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



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- 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

To learn how to ask us to pay you back for our share of the cost of the drug, see Chapter 7, Section A, page 147.

3. Send us information about the 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. This can help you qualify for catastrophic coverage. When you reach the Catastrophic Coverage Stage, SCFHP Cal MediConnect pays all of the costs of your Part D drugs for the rest of the year.

4. Check the reports we send you.

When you get an *Explanation of Benefits* in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call SCFHP Cal MediConnect Customer Service. Be sure to keep these reports. They are an important record of your drug expenses.

C. Drug Payment Stages for Medicare Part D drugs

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

Stage 1: Initial Coverage Stage	Stage 2: Catastrophic Coverage Stage
<p>During this stage, we pay part of the costs of your drugs, and you pay your share. Your share is called the copay.</p> <p>You begin in this stage when you fill your first prescription of the year.</p>	<p>During this stage, we pay all of the costs of your drugs through December 31, 2021.</p> <p>You begin this stage when you have paid a certain amount of out-of-pocket costs.</p>

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



D. Stage 1: The Initial Coverage Stage

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

Cost-sharing tiers are groups of drugs with the same copay. Every drug in the plan's Drug List is in one of four cost-sharing tiers. In general, the higher the tier number, the higher the copay. To find the cost-sharing tiers for your drugs, you can look in the Drug List.

- Tier 1 drugs are generic drugs. The copay is \$0.
- Tier 2 drugs are brand name drugs. The copay is from \$0 to \$9.20, depending on your income (highest cost-sharing tier).
- Tier 3 drugs are non-Medicare prescription drugs that are covered by Medi-Cal. The copay is \$0.
- Tier 4 drugs are non-Medicare over-the-counter (OTC) drugs that are covered by Medi-Cal. The copay is \$0.

D1. Your pharmacy choices

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

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

In limited cases, we cover prescriptions filled at out-of-network pharmacies. See Chapter 5, Section A, page 120 to find out when we will do that.

To learn more about these pharmacy choices, see Chapter 5, Section A, page 120, in this handbook and our *Provider and Pharmacy Directory*.

D2. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. It costs you the same as a one-month supply.

For details on where and how to get a long-term supply of a drug, see Chapter 5, Section A7, page 122 or the *Provider and Pharmacy Directory*.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

D3. What you pay

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

You can contact SCFHP Cal MediConnect Customer Service to find out how much your copay is for any covered drug.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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

	A network pharmacy A one-month or up to a 90-day supply	The plan's mail-order service A one-month or up to a 90-day supply	A network long-term care pharmacy Up to a 90-day supply	An out-of-network pharmacy Up to a 31-day supply. Coverage is limited to certain cases. See Chapter 5, Section C, page 125 for details.
Cost-sharing Tier 1 (Generic drugs)	\$0	\$0	\$0	\$0
Cost-sharing Tier 2 (Brand name drugs)	\$0 to \$9.20	\$0 to \$9.20	\$0 to \$9.20	\$0 to \$9.20
Cost-sharing Tier 3 (Non-Medicare prescription drugs)	\$0	\$0	\$0	\$0
Cost-sharing Tier 4 (Non-Medicare over-the-counter (OTC) drugs)	\$0	\$0	\$0	\$0

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



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

D4. End of the Initial Coverage Stage

The Initial Coverage Stage ends when your total out-of-pocket costs reach \$6,550. At that point, the Catastrophic Coverage Stage begins. We cover all your drug costs from then until the end of the year.

Your *Explanation of Benefits* reports will help you keep track of how much you have paid for your drugs during the year. We will let you know if you reach the \$6,550 limit. Many people do not reach it in a year.

E. Stage 2: The Catastrophic Coverage Stage

When you reach the out-of-pocket limit of \$6,550 for your prescription drugs, the Catastrophic Coverage Stage begins. You will stay in the Catastrophic Coverage Stage until the end of the calendar year. During this stage, the plan will pay all of the costs for your Medicare drugs.

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

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

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

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

- Here's an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is 4.00. This means that the amount you pay for your drug is a little more than \$0.13 per day. If you get a 7 days' supply of the drug, your payment will be a little more than \$0.13 per day multiplied by 7 days, for a total payment of \$0.90.
- Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- You can also ask your provider to prescribe less than a full month's supply of a drug, if this will help you:
 - better plan when to refill your drugs,
 - coordinate refills with other drugs you take, and
 - take fewer trips to the pharmacy.

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

G1. What the AIDS Drug Assistance Program (ADAP) is

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

G2. What to do if you aren't enrolled in ADAP

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-844-421-7050 or go to the ADAP website at www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_adap_eligibility.aspx.

G3. What to do if you're already enrolled in ADAP

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

H. Vaccinations

We cover Medicare Part D vaccines. There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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

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

We recommend that you call us first at SCFHP Cal MediConnect Customer Service whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your costs down by using network pharmacies and providers. Network pharmacies are pharmacies that have agreed to work with our plan. A network provider is a provider who works with the health plan. A network provider should work with SCFHP Cal MediConnect to ensure that you do not have any upfront costs for a Part D vaccine.

H2. What you pay for a Medicare Part D vaccination

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

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4, Section D, page 84.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List. You may have to pay a copay for Medicare Part D vaccines.

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

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
 - You will pay a copay for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office and the doctor gives you the shot.
 - You will pay a copay to the doctor for the vaccine.
 - Our plan will pay for the cost of giving you the shot.
 - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay a copay for the vaccine.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
 - You will pay a copay for the vaccine.
 - Our plan will pay for the cost of giving you the shot.

Please see Chapter 4, Section D, page 84 of this *Member Handbook* or see the Drug List to find the copay for a specific vaccine.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs

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 the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



A. Asking us to pay for your services or drugs

Our network providers must bill the plan for your covered services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for the full cost of health care or drugs, send the bill to us. To send us a bill, see Chapter 7, Section B, page 149.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid more than your share of the cost, it is your right to be paid back.
- If the services or drugs are **not** covered, we will tell you.

Contact SCFHP Cal MediConnect Customer Service if you have any questions. If you do not know what you should have paid, or if you get a bill and you do not 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

You should 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 do not 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 have already paid for the service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. Show your SCFHP Cal MediConnect Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call SCFHP Cal MediConnect Customer Service if you get any bills.**



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- Because SCFHP Cal MediConnect Plan pays the entire cost for your medical 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 have 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 go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back for our share of the cost.
- Please see Chapter 5, Section A, page 120 to learn more about out-of-network pharmacies.

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call us or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription for a drug that is not covered

You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on our *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
 - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9, Section D, page 170).

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9, Section E2, page 175).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for our share of the cost of the service or drug. If we deny your request for payment, you can appeal our decision.

To learn how to make an appeal, see Chapter 9, Section D, page 170.

B. Sending a request for payment

Health care services and items

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can call SCFHP Cal MediConnect Customer Service to ask for help.

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

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.scfhp.com), or you can call SCFHP Cal MediConnect Customer Service and ask for the form.

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

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

You may also call us to request payment. Call SCFHP Cal MediConnect Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

You must submit your claim to SCFHP within 180 days of the date you got the service, item, or drug.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Prescription drugs

Send MedImpact your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It is a good idea to make a copy of your bill and receipts for your records.** You can call SCFHP Cal MediConnect Customer Service to ask for help.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form (Part D Prescription Drug Claim Form) to make your request for payment.

- You do not have to use the form, but it will help us process the information faster.
- You can get a copy of the form on our website (www.scfhp.com), or you can call SCFHP Cal MediConnect Customer Service and ask for the form.

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

MedImpact Healthcare Systems, Inc.
P.O. Box 509108
San Diego, CA 92150-9108

Or send your request by fax to 1-858-549-1569 or by email to claims@medimpact.com.

Call SCFHP Cal MediConnect Customer Service for help at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

You must submit your claim to MedImpact within 180 days of the date you got the item or drug.

C. Coverage decisions

When we get your request for payment, we will make a coverage decision. This means that we will decide whether your health care or drug is covered by our plan. We will also decide the amount of money, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay our share of the cost for it. If you have already paid for the service or drug, we will mail you a check for our share of the cost. If you have not paid for the service or drug yet, we will pay the provider directly.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 3, Section B, page 45 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for our share of the cost of the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, see Chapter 9, Section D, page 170.

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 do not agree with the amount we pay.

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9, Section D, page 170.

- If you want to make an appeal about getting paid back for a health care service, go to page 177.
- If you want to make an appeal about getting paid back for a drug, go to page 196.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Chapter 8: Your rights and responsibilities

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 the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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

We must tell you about the 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 SCFHP Cal MediConnect Customer Service. Our plan has people who can 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. We can give you written information in English, Spanish, Vietnamese, Chinese, or Tagalog if you need it. If you would like to make a standing request to get materials, now and in the future, in a language other than English, Spanish, Vietnamese, Chinese, or Tagalog, or in an alternate format, call SCFHP Cal MediConnect Customer Service or send a request in writing to:

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. The Medi-Cal Managed Care Office of the Ombudsman helps people who are enrolled in Medi-Cal. They can help you file a complaint. You can call them at 1-888-452-8609.

Debemos informarle sobre los beneficios del plan y sobre sus derechos de manera que pueda entenderlos. Debemos informarle sobre sus derechos cada año que pertenezca a nuestro plan.

- Para obtener información de una forma que pueda comprender, llame a Servicio al Cliente de SCFHP Cal MediConnect. Nuestro plan tiene personas que pueden responder a sus preguntas en diferentes idiomas.
- Nuestro plan también puede proporcionarle material en idiomas distintos del inglés y en formatos, como letra grande, braille o audio. Si lo necesita, podemos proporcionarle información escrita en inglés, español, vietnamita, chino o tagalo. Si desea hacer una solicitud permanente para obtener materiales, ahora y de aquí en adelante, en un idioma distinto al inglés, español, vietnamita, chino o



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tagalo, o en un formato alternativo, llame a Servicio al Cliente de SCFHP Cal MediConnect o envíe una solicitud por escrito a la siguiente dirección:

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Si tiene problemas para obtener la información de nuestro plan debido a problemas de idioma o una discapacidad y desea presentar una queja, llame a Medicare al 1800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los siete días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. La Oficina del Ombudsman para los servicios médicos administrados por Medi-Cal ayuda a las personas que están inscritas en Medi-Cal. Ellos podrán ayudarlo a presentar una queja. Puede llamarlos al 1-888-452-8609.

Chúng tôi phải cho quý vị biết về các phúc lợi của chương trình và các 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 mỗi năm khi quý vị còn trong chương trình của chúng tôi.

- Để nhận thông tin theo cách quý vị có thể hiểu được, hãy gọi tới Dịch Vụ Khách Hàng của SCFHP Cal MediConnect. Chương trình của chúng tôi có người có thể trả lời các câu hỏi bằng những ngôn ngữ khác nhau.
- Chương trình của chúng tôi sẽ cung cấp cho quý vị tài liệu bằng những ngôn ngữ khác ngoài tiếng Anh và trong những định dạng như chữ in cỡ lớn, chữ nổi hoặc âm thanh. Chúng tôi có thể cung cấp thông tin cho quý vị dưới dạng văn bản bằng tiếng Anh, tiếng Tây Ban Nha, tiếng Việt, tiếng Trung hoặc tiếng Tagalog nếu quý vị cần. Nếu quý vị muốn yêu cầu nhận tài liệu lâu dài, cả hiện tại và trong tương lai, bằng một ngôn ngữ khác ngoài tiếng Anh, tiếng Tây Ban Nha, tiếng Việt, tiếng Trung hoặc tiếng Tagalog, hay nhận tài liệu ở định dạng khác, hãy gọi tới Phòng Dịch Vụ Khách Hàng của SCFHP Cal MediConnect hoặc gửi yêu cầu bằng văn bản đến:

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Nếu quý vị gặp khó khăn trong việc lấy thông tin từ chương trình của chúng tôi vì trở ngại ngôn ngữ hoặc do khuyết tật và quý vị muốn gửi khiếu nại, xin gọi Medicare tại số 1800MEDICARE (1-800-633-4227). Quý vị có thể gọi 24 giờ một ngày, 7 ngày một tuần. Người dùng TTY nên gọi số 1-877-486-2048. Văn Phòng Thanh Tra của Chương Trình

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chăm Sóc Có Quản Lý thuộc Medi-Cal giúp đỡ những người ghi danh vào Medi-Cal. Họ có thể giúp quý vị gửi khiếu nại. Quý vị có thể gọi tới số 1-888-452-8609.

我们必须以您能够理解的方式向您告知本计划的福利和您的权利。我们必须向您告知，您在参与计划期间每年所拥有的权利。

- 若要以您能够理解的方式获取信息，请致电 SCFHP Cal MediConnect 客户服务部。我们的计划雇有能用不同语言回答问题的员工。
- 我们的计划也可以为您提供除英语之外其他语种以及大号字体、盲文或音频等格式的资料。若您需要，我们可提供英语、西班牙语、越南语、中文或塔加拉族语等语种的书面信息。无论现在还是将来，如果您想持续请求获得除英语、西班牙语、越南语、中文或塔加拉族语之外其他语种或其他格式的文档，请致电 SCFHP Cal MediConnect 客户服务部或寄送书面请求至：

Attn: Customer Service Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

如果您因语言问题或残疾而无法获取我们计划的信息，并且您要提出投诉，请致电 1-800-MEDICARE (1-800-633-4227) 与 Medicare 联系。我们提供全年全天候的专线服务。TTY 用户请致电 1-877-486-2048。Medi-Cal 管理式护理监察专员办公室可以为 Medi-Cal 投保人士提供帮助。他们可以帮您提出投诉。您可以致电 1-888-452-8609 与他们联系。

Dapat naming sabihin sa iyo ang tungkol sa mga benepisyo ng plano at ang iyong mga karapatan sa isang paraang mauunawaan mo. Dapat naming sabihin sa iyo ang tungkol sa iyong mga karapatan sa bawat taon na ikaw ay nasa plano namin.

- Upang makakuha ng impormasyon sa isang paraang nauunawaan mo, tumawag sa Customer Service ng SCFHP Cal MediConnect. Ang aming plano ay may mga tao na makakasagot sa mga katanungan sa iba't ibang wika.
- Ang aming plano ay maari ka din bigyan ng mga materyales kahit anong wika bukod sa Ingles at sa mga format na tulad ng malalaking imprenta, braille, o audio. Maaari ka naming bigyan ng nakasulat na impormasyon sa Ingles, Espanyol, Vietnamese, Tsino, o Tagalog kung kailangan mo ito. Kung gusto mong gumawa ng patuloy na kahilingan para makakuha ng mga materyales, ngayon at sa hinaharap, sa ibang wikang hindi Ingles, Espanyol, Vietnamese, Tsino, o Tagalog, o sa isang alternatibong format, tumawag sa Customer Service ng SCFHP Cal MediConnect o magpadala ng nakasulat na kahilingan sa:



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Attn: Customer Service Department
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San Jose, CA 95158

Kung nagkakaproblema ka sa pagkuha ng impormasyon mula sa aming plano dahil sa mga problema sa wika o kapansanan at nais mong maghain ng reklamo, tawagan ang Medicare sa 1-800-MEDICARE (1-800-633-4227). Maaari kang tumawag 24 na oras sa isang araw, 7 araw sa isang linggo. Dapat tumawag sa 1-877-486-2048 ang mga gumagamit ng TTY. Ang Tanggapan ng Ombudsman ng Med-Cal Managed Care ay tumutulong sa mga taong nakatala sa Medi-Cal. Matutulungan ka nilang maghain ng reklamo. Maaari mo silang tawagan sa 1-888-452-8609.

B. Our responsibility to ensure that you get timely access to covered services and drugs

If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

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 about what types of providers may act as a PCP and how to choose a PCP in Chapter 3, Section D, page 47. Call SCFHP Cal MediConnect Customer Service or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- Women have the right to go to a women's health specialist without getting a referral. A referral is approval from your PCP to see someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
 - This includes the right to get timely services from specialists.
- 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 see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, page 43.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- 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, see Chapter 1, Section F, page 11.
- You have the right to self-direct care with help from your care team and case manager.

Chapter 9, page 165 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section D, page 170 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

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 the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights to get information and to control how your PHI is used. We give you a written notice that tells about these rights and also explains how we protect the privacy of your health information. The notice is called the “Notice of Privacy Practices.”

C1. How we protect your PHI

We make sure that unauthorized people do not see or change your records.

In most situations, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.

There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.

- We are required to release health information to government agencies that are checking on our quality of care.
- We are required to release health information by court order.
- We are required to give Medicare your health and drug information. If Medicare releases your information for research or other uses, it will be done according to federal laws. We are also required to give Medi-Cal your health and drug



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

information. If Medi-Cal releases your information for research or other uses, it will be done according to federal laws.

C2. You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a fee for making a copy of your medical records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call SCFHP Cal MediConnect Customer Service.

You can learn more about your privacy rights by reading SCFHP's Notice of Privacy Practices, in Chapter 11, Section F, page 233. The Notice of Privacy Practices is also available on our website at www.scfhp.com, or can be requested by calling SCFHP Cal MediConnect Customer Service.

D. Our responsibility to give you information about our plan, our network providers, and your covered services

As a member of SCFHP Cal MediConnect, you have the right to get information from us. If you do not speak English, we have interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at 1-877-723-4795 (TTY: 711), Monday through 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, audio, or other languages.

If you want information about any of the following, call SCFHP Cal MediConnect Customer Service:

- How to choose or change plans
- Our plan, including:
 - Financial information
 - How we have been rated by plan members
 - The number of appeals made by members
 - How to leave our plan
- Our network providers and our network pharmacies, including:

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- 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 and drugs 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, including asking us to:
 - Put in writing why something is not covered
 - Change a decision we made
 - Pay for a bill you got

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 charge you if we pay less than the provider charged. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, Section A, page 147 and Section B, page 149.

F. Your right to leave our Cal MediConnect Plan

No one can make you stay in our plan if you do not want to. If you leave our plan:

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- See Chapter 10, Section C, page 222 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- Your Medi-Cal benefits will continue to be offered through SCFHP unless you choose a different plan available in this county.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

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

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to see 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 also have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, you will not be dropped 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 has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9, Section D, page 170 and Section F, page 188 tell how to ask the plan for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

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

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



The legal document that you can 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 do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Medi-Cal, such as the Health Insurance Counseling & Advocacy Program (HICAP), may also have advance directive forms. You can also get a form from the SCFHP website (www.scfhp.com) or contact SCFHP Cal MediConnect Customer Service to ask for the form.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital.**
 - The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
 - If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

G3. What to do if your instructions are not followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint:

- with SCFHP Cal MediConnect; **or**
- about a doctor with the Medical Board of California. For information about how to file a complaint with the Medical Board of California, call 1-800-633-2322
- about a hospital with the California Department of Public Health (CDPH).
 - To file a complaint with CDPH, fill out the online consumer complaint form at <http://hfcis.cdph.ca.gov/longtermcare/consumercomplaint.aspx>.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You may also contact the CDPH Licensing and Certification District Office for the district in which the hospital is located; **or**
- You may call the CDPH Consumer Information System at 1-800-236-9747.

H. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, page 165 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call SCFHP Cal MediConnect Customer Service.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly — and it is **not** about discrimination for the reasons listed in Chapter 11, Section B, page 230 — or you would like more information about your rights, you can get help by calling:

- Customer Service.
- Health Insurance Counseling & Advocacy Program (HICAP) program. For details about this organization and how to contact it, see Chapter 2, Section E, page 26.
- The Cal MediConnect Ombuds Program. For details about this organization and how to contact it, see Chapter 2, Section I, page 30.
- 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.)

I. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call SCFHP Cal MediConnect Customer Service.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- Covered services, see Chapter 3, page 43 and Chapter 4, page 63. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
- Covered drugs, see Chapter 5, page 117 and Chapter 6, page 135.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Customer Service if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
 - Give them the 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 are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - Some Medi-Cal beneficiaries must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal benefits. This is called share of cost, and it is similar to a private insurance plan's out-of-pocket deductible.
 - Medicare Part A and Medicare Part B premiums. For most SCFHP Cal MediConnect members, Medi-Cal pays for your Part A premium and your Part B premium.
 - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copay (fixed amount). Chapter 6, Section C, page 138 tells what you must pay for your drugs.
 - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** If you disagree with our decision to not cover a



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- service or drug, you can make an appeal. Please see Chapter 9, Section D, page 170 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Customer Service.
 - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get SCFHP Cal MediConnect. Chapter 1, Section D, page 9 tells about our service area.
 - We can help you figure out whether you are moving outside our service area.
 - Also, be sure to let Medicare and Medi-Cal know your new address when you move. See Chapter 2, page 18 for phone numbers for Medicare and Medi-Cal.
 - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
 - Call Customer Service for help if you have questions or concerns.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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 has said it will not pay for.
- You disagree with a decision your plan has 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 Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Nursing Facility (NF) services.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long-term services and supports

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 are having a problem with your care, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077 for help.** This chapter explains the different options you have for different problems and complaints, but you can always call the Cal MediConnect Ombuds Program to help guide you through your problem. For additional resources to address your concerns and ways to contact them, see Chapter 2, Section I, page 30 for more information on ombudsman programs.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

A. What to do if you have a problem

This chapter tells you what to do if you have a problem with your plan or with your services or payment. Medicare and Medi-Cal approved these processes. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

A1. About the legal terms

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- “Making a complaint” rather than “filing a grievance”
- “Coverage decision” rather than “organization determination,” “benefit determination,” “at-risk determination,” or “coverage determination”
- “Fast coverage decision” rather than “expedited determination”

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to call for help

B1. Where to get more information and help

Sometimes it can be confusing to start or follow the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the Cal MediConnect Ombuds Program

If you need help, you can always call the Cal MediConnect Ombuds Program. The Cal MediConnect Ombuds Program is an ombudsman program that can answer your questions and help you understand what to do to handle your problem. The Cal MediConnect 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 phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free. See Chapter 2, Section I, page 30 for more information on ombudsman programs.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



You can get help from the Health Insurance Counseling & Advocacy Program

You can also call the Health Insurance Counseling and Advocacy Program (HICAP). HICAP counselors can answer your questions and help you understand what to do to handle your problem. HICAP 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.

Getting help from Medicare

You can call Medicare directly for help with problems. 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: 1-877-486-2048. The call is free.
- Visit the Medicare website at www.medicare.gov.

You can get help from the California Department of Managed Health Care

In this paragraph, the term “grievance” means an appeal or complaint about Medi-Cal services, your health plan, or one of your providers.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-723-4795** (TTY: 711), and use your health plan's 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 your health plan, or a grievance that has remained unresolved for more than 30 days, 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 TTY line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet website www.dmhc.gov has complaint forms, IMR application forms and instructions online.

You can get help from the Quality Improvement Organization (QIO)

Our state has an organization called Livanta BFCC-QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Contact Livanta BFCC-QIO if you have a problem with the quality of care you have received, you think your hospital stay is ending too soon or you think your home health care, skilled nursing facility care or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

See Chapter 2, Section F, page 27 for Livanta BFCC-QIO contact information.

C. Problems with your benefits

C1. Using the process for coverage decisions and appeals or for making a complaint

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

<p>Is your problem or concern about your benefits or coverage?</p> <p>(This includes problems about whether particular medical care, long-term services and supports, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)</p>	
<p>Yes.</p> <p>My problem is about benefits or coverage.</p> <p>Go to Section D: “Coverage decisions and appeals” on page 170.</p>	<p>No.</p> <p>My problem is not about benefits or coverage.</p> <p>Skip ahead to Section J: “How to make a complaint” on page 214.</p>

D. Coverage decisions and appeals

D1. Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment. You are not responsible for Medicare costs except Part D copays.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



What is a coverage decision?

A coverage decision is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your doctor is not sure if a service, item, or drug is covered by Medicare or Medi-Cal, either of you can ask for a coverage decision before the doctor gives the service, item, or drug.

What is an appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is no longer covered by Medicare or Medi-Cal. If you or your doctor disagree with our decision, you can appeal.

D2. Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- Call **Customer Service** at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. The phone number is 1-855-501-3077.
- Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
- Call 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 enrolled in Cal MediConnect 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 TTY number, 1-877-688-9891.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - If you want a friend, relative, or other person to be your representative, call Customer Service 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 or on our website at www.scfhp.com. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may 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. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. You can ask for a legal aid attorney from the Health Consumer Alliance at 1-888-804-3536.
 - However, **you do not have to have a lawyer** to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E on page 174** gives you information if you have problems about services, items, and drugs (but **not** Part D drugs). For example, use this section if:
 - You are not getting medical care you want, and you believe our plan covers this care.
 - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered.
 - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with an asterisk (*) are not covered by Part D. See Section F on page 188 for Part D drug appeals.
 - You got medical care or services that you think should be covered, but we are not paying for this care.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- You got and paid for medical services or items you thought were covered, and you want to ask us to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
 - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections G and H on pages 200 and 206.
- **Section F on page 188** gives you information about Part D drugs. For example, use this section if:
 - You want to ask us to make an exception to cover a Part D drug that is not on our Drug List.
 - You want to ask us to waive limits on the amount of the drug you can get.
 - You want to ask us to cover a drug that requires prior approval.
 - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
 - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 200** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
 - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section H on page 206** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should use, please call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

If you need other help or information, please call the Cal MediConnect Ombuds Program at 1-855-501-3077.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

This section is about what to do if you have problems with your benefits for your medical, behavioral health, and long-term services and supports (LTSS). You can also use this section for problems with drugs that are **not** covered by Part D, including Medicare Part B drugs. Drugs in the Drug List with an asterisk (*) are **not** covered by Part D. Use Section F for Part D drug Appeals.

This section tells what you can do if you are in any of the following situations:

1. You think we cover medical, behavioral health, or long-term services and supports (LTSS) you need but are not getting.

What you can do: You can ask us to make a coverage decision. Go to Section E2 on page 175 for information on asking for a coverage decision.

2. We did not approve care your doctor wants to give you, and you think we should have.

What you can do: You can appeal our decision to not approve the care. Go to Section E3 on page 177 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

What you can do: You can appeal our decision not to pay. Go to Section E3 on page 177 for information on making an appeal.

4. You got and paid for services or items you thought were covered, and you want us to reimburse you for the services or items.

What you can do: You can ask us to pay you back. Go to Section E5 on page 187 for information on asking the plan for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

What you can do: You can appeal our decision to reduce or stop the service. Go to Section E3 on page 177 for information on making an appeal.

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



(CORF) services, special rules apply. Read Section G, page 200 or Section H, page 206 to find out more.

E2. Asking for a coverage decision

How to ask for a coverage decision to get medical, behavioral health, or certain long-term services and supports (MSSP, CBAS, or NF services)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: 1-877-723-4795. TTY: 711.
- You can fax us at: 1-408-874-1957.
- You can write to us at:

Attn: Utilization Management
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

How long does it take to get a coverage decision?

After you ask and we get all of the information we need, it usually takes 5 business days for us to make a decision unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we do not give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

The legal term for “fast coverage decision” is “expedited determination.”

Asking for a fast coverage decision:

- Start by calling or faxing to ask us to cover the care you want.
- Call us at 1-877-723-4795 (TTY: 711), or fax us at 1-408-874-1957.
- Find other details on how to contact us, go to Chapter 2, Section A, page 20.

You can also ask your provider or your representative to request a fast coverage decision for you.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

1. You can get a fast coverage decision **only if you are asking for coverage for care or an item you have not yet received**. (You cannot ask for a fast coverage decision if your request is about payment for care or an item you already got).
2. You can get a fast coverage decision **only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function**.
 - If your doctor says that you need a fast coverage decision, we will automatically give you one.
 - If you ask for a fast coverage decision, without your doctor’s support, we will decide if you get a fast coverage decision.
 - If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell 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 the process for making complaints, including fast complaints, see Section J on page 214.)

If the coverage decision is No, how will I find out?

If the answer is **No**, we will send you a letter telling you our reasons for saying **No**.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- If we say **No**, you have the right to ask us to change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (read the next section for more information).

E3. Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An appeal is a formal way of asking us to review our decision and change it if you think we made a mistake. If you or your doctor or other provider disagree with our decision, you can 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. Go to page 181 for more information. If you need help during the appeals process, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plans.

What is a Level 1 Appeal?

A Level 1 Appeal is the first appeal to our plan. We will review our coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing.

If we tell you after our review that the service or item is not covered, your case can go to a Level 2 Appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal (see page 204).
- If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is in process (see page 180).
- Keep reading this section to learn about what deadline applies to your appeal.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

How do I make a Level 1 Appeal?

- To start your appeal, you, your doctor or other provider, or your representative must contact us. You can call us at 1-877-723-4795. For additional details on how to reach us for appeals, see Chapter 2, page 18.
- You can ask us for a “standard appeal” or a “fast appeal.”
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
 - You can submit a written request to the following address:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158
 - You can submit your request online at: www.scfhp.com.
 - You may also ask for an appeal by calling us at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- We will send you a letter from us within 5 calendar days of receiving your appeal letting you know that we received it.

The legal term for “fast appeal” is “expedited reconsideration.”

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Customer Service and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf, or our website at www.scfhp.com.

If the appeal comes from someone besides you or your doctor or other provider, we must get the completed Appointment of Representative form before we can review the appeal.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information,** visit www.scfhp.com.



How much time do I have to make an 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 this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal. You should explain the reason your appeal is late when you make your appeal.

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read “Will my benefits continue during Level 1 appeals” on page 180 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

Can my doctor give you more information about my appeal?

Yes, you and your doctor may give us more information to support your appeal.

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care. Then, we check to see if we were following all the rules when we said **No** to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a “standard” appeal decision?

We must give you our answer within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your health condition requires us to.

- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug), we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information,** visit www.scfhp.com.

- If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 on page 181.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about coverage of a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 on page 181.

When will I hear about a “fast” appeal decision?

If you ask for a fast appeal, we will give you our answer within 72 hours after we get your appeal. We will give you our answer sooner if your health requires us to do so.

- If we do not give you an answer to your appeal within 72 hours, we will automatically send your case to Level 2 of the appeals process if your problem is about coverage of a Medicare service or item. You will be notified when this happens.
- If your problem is about coverage of a Medi-Cal service or item, you will need to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 on page 181.

If our answer is Yes to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for a Level 2 Appeal. If your problem is about a Medi-Cal service or item, the letter will tell you how to file a Level 2 Appeal yourself. For more information about the Level 2 Appeal process, go to Section E4 on page 181.

Will my benefits continue during Level 1 appeals?

If we decide to change or stop coverage for a service or item that was previously approved, we will send you a notice before taking the action. If you disagree with the action, you can file a Level 1 Appeal and ask that we continue your benefits for the service or item. You must **make the request on or before the later of the following** in order to continue your benefits:

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- Within 10 days of the mailing date of our notice of action; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item while your appeal is processing.

E4. Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says No at Level 1, what happens next?

If we say **No** to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare or Medi-Cal.

- If your problem is about a **Medicare** service or item, we will 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 **Medi-Cal** service or item, you can file a Level 2 Appeal yourself. The letter will tell you how to do this. Information is also below.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal, which is done by an independent organization that is not connected to our plan.

My problem is about a Medi-Cal service or item. How can I make a Level 2 Appeal?

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.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- 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.

In most cases, you must file an appeal with us before requesting an IMR. See page 177 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. 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.a

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



[spx](#) or by calling 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 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 seeing 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 request 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.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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 185 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:
 - 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.

My problem is about a Medicare service or item. What will happen at the Level 2 Appeal?

An Independent Review Entity (IRE) will carefully review the Level 1 decision and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be notified when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Customer Service at 1-877-723-4795.

The IRE must give you an answer to your Level 2 Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. The IRE must give you an answer within 72 hours of when it gets your appeal.

- However, if the IRE needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription.

Will my benefits continue during Level 2 appeals?

If your problem is about a service or item covered by Medicare, your benefits for that service or item will not continue during the Level 2 appeals process with the Independent Review Entity.

If your problem is about a service or item covered by Medi-Cal and you ask for a State Hearing, your Medi-Cal benefits for that service or item can continue until a hearing decision is made. You must ask for a hearing **on or before the later of the following** in order to continue your benefits:

- Within 10 days of the mailing date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld; **or**
- The intended effective date of the action.

If you meet this deadline, you can keep getting the disputed service or item until the hearing decision is made.

How will I find out about the decision?

If your Level 2 Appeal was an Independent Medical Review, the Department of Managed Health Care will send you a letter explaining the decision made by the doctors who reviewed your case.

- If the Independent Medical Review decision is **Yes** to part or all of what you asked for, we must provide the service or treatment.
- If the Independent Medical Review decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. You can still get a State Hearing. Go to page 183 for information about asking for a State Hearing.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

If your Level 2 Appeal was a State Hearing, the California Department of Social Services will send you a letter explaining its decision.

- If the State Hearing decision is **Yes** to part or all of what you asked for, we must comply with the decision. We must complete the described action(s) within 30 calendar days of the date we received a copy of the decision.
- If the State Hearing decision is **No** to part or all of what you asked for, it means they agree with the Level 1 decision. We may stop any aid paid pending you are receiving.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), it will send you a letter explaining its decision.

- If the IRE says **Yes** to part or all of what you asked for in your standard appeal, we must authorize the medical care coverage within 72 hours or give you the service or item within 14 calendar days from the date we get the IRE's decision. If you had a fast appeal, we must authorize the medical care coverage or give you the service or item within 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

If the decision is No for all or part of what I asked for, can I make another appeal?

If your Level 2 Appeal was an Independent Medical Review, you can request a State Hearing. Go to page 183 for information about asking for a State Hearing.

If your Level 2 Appeal was a State Hearing, you may ask for a rehearing within 30 days after you receive the decision. You may also ask for judicial review of a State Hearing denial by filing a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after you receive the decision. You cannot ask for an IMR if you already had a State Hearing on the same issue.

If your Level 2 Appeal went to the Medicare Independent Review Entity (IRE), you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



See Section I on page 213 for more information on additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is the copay for tier 2 drugs, as applicable.

If you get a bill that is more than your copay for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: Asking us to pay our share of a bill you have gotten for covered services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see 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 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 will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal.** Follow the appeals process described in Section E3 on page 177. When you follow these instructions, please note:



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- If you make an appeal for reimbursement, we must give you our answer within 30 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity (IRE). We will notify you by letter if this happens.

- If the IRE 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 you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”) The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section I on page 213 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Medi-Cal, you can file a Level 2 Appeal yourself (see Section E4 on page 181).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are “Part D drugs.” There are a few drugs that Medicare Part D does not cover but that Medi-Cal may cover. **This section only applies to Part D drug appeals.**

The Drug List includes some drugs with an asterisk (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an asterisk (*) symbol follow the process in Section E on page 174.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
 - Asking us to cover a Part D drug that is not on the plan's Drug List
 - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

The legal term for a coverage decision about your Part D drugs is “**coverage determination.**”

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you how to ask for coverage decisions **and** how to request an appeal.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Use the chart below to help you decide which section has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section F2 on page 190. Also see Sections F3 and F4 on pages 191 and 193.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section F4 on page 193.</p>	<p>Do you want to ask us to pay you back for a drug you already got and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to F4 on page 193 .</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section F5 on page 196.</p>

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List or is not covered in the way you would like, you can ask us to make an “exception.”

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

- Covering a Part D drug that is not on our Drug List.
 - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 2.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- You cannot ask for an exception to the copay or coinsurance amount we require you to pay for the drug.
2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, page 125).
- The extra rules and restrictions on coverage for certain drugs include:
 - Being required to use the generic version of a drug instead of the brand name drug.
 - Getting plan approval before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - Quantity limits. For some drugs, we limit the amount of the drug you can have.
 - If we agree to make an exception and waive a restriction for you, you can still ask for an exception to the copay amount we require you to pay for the drug.

The legal term for asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

F3. Important things to know about asking for exceptions

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 requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We will say Yes or No to your request for an exception

- If we say **Yes** to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say **No** to your request for an exception, you can ask for a review of our decision by making an appeal. Section F5 on page 196 tells how to make an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Read Section D on page 170 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, page 147 of this handbook. Chapter 7 describes times when you may need to ask

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- If you are asking for an exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the “supporting statement.”
- Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

If your health requires it, ask us to give you a “fast coverage decision”

We will use the “standard deadlines” unless we have agreed to use the “fast deadlines.”

- A **standard coverage decision** means we will give you an answer within 72 hours after we get your doctor’s statement.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor’s statement.

The legal term for “fast coverage decision” is “**expedited coverage determination.**”

You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you already bought.)

You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether you get a fast coverage decision.
- If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
 - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You can file a “fast complaint” and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, see Section J on page 214.

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor’s or prescriber’s statement supporting your request. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor’s or prescriber’s statement supporting your request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request. Or, if you are asking for an exception, after we get your doctor’s or prescriber’s supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor’s or prescriber’s supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a “standard coverage decision” about payment for a drug you already bought

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request **within 60 calendar days** from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

At a glance: How to make a Level 1 Appeal

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **“redetermination.”**

If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section F4 on page 193.

The legal term for “fast appeal” is **“expedited redetermination.”**

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said **No** to your request. We may contact you or your doctor or other prescriber to get more information. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. If you think your health requires it, you should ask for a “fast appeal.”
- If we do not give you a decision within 7 calendar days, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your appeal.
- **If our answer is Yes** to part or all of what you asked for:
 - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.
 - If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term for an appeal to the IRE about a Part D drug is **“reconsideration.”**

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a “fast appeal.”
- If the IRE agrees to give you a “fast appeal,” it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE says **Yes** to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
- If the IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called “upholding the decision.” It is also called “turning down your appeal.”

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. Asking us to cover a longer hospital stay

When you are 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.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your “discharge date.”
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

G1. Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called “An Important Message from Medicare about Your Rights.” If you do not get this notice, ask any hospital employee for it. If you need help, please call Customer Service at 1-877-723-4795. 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 this notice carefully and ask questions if you don’t understand. The “Important Message” 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 are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. 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. The call is free.
- You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.
- If you need help, please call Customer Service at 1-877-723-4795 or Medicare at the numbers listed above.

G2. Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you. In California, the Quality Improvement Organization is called Livanta BFCC-QIO.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



To make an appeal to change your discharge date call Livanta BFCC-QIO at: 1-877-588-1123, available 24 hours a day, 7 days a week. TTY users should call 1-855-887-6668.

Call right away!

Call the Quality Improvement Organization **before** you leave the hospital and no later than your planned discharge date. “An Important Message from Medicare about Your Rights” contains information on how to reach the Quality Improvement Organization.

- **If you call before you leave**, you are allowed to stay in the hospital after your planned discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section G4 on page 204.
- 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 (DMHC) for an Independent Medical Review. Please go to Section E4 on page 181 to learn how to file a complaint and ask the DMHC for an Independent Medical Review.

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-877-588-1123 and ask for a “fast review.”

Call before you leave the hospital and before your planned discharge date.

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. You can also call the Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222. Or you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a “fast review”

You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

The legal term for “fast review is “**immediate review.**”

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample by calling Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. 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. Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



What if the answer is No?

- If the Quality Improvement Organization says **No** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal as described in the next section.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: **1-877-588-1123**.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-877-588-1123 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

You may also file a complaint with or ask the DMHC for an Independent Medical Review to continue your hospital stay. Please go to Section E4 on page 181 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review.

G4. What happens if you miss an appeal deadline

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. This means we will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes to your fast review**, it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

At a glance: How to make a Level 1 Alternate Appeal

Call our Customer Service number and ask for a “fast review” of your hospital discharge date.

We will give you our decision within 72 hours.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.
- **If we say No to your fast review**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
 - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the Independent Review Entity. When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “**expedited appeal.**”

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 214 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

must also continue our coverage of your hospital services for as long as it is medically necessary.

- If this organization says **No** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
- The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

You may also file a complaint with and ask the DMHC for an Independent Medical Review to continue your hospital stay. Please go to Section E4 on page 181 to learn how to file a complaint with and ask the DMHC for an Independent Medical Review. You can ask for an Independent Medical Review in addition to or instead of a Level 3 Appeal.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
 - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
 - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two days before we stop paying for your care. This is called the “Notice of Medicare Non-Coverage.”

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section J on page 214 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. Or call your State Health Insurance Assistance Program (Health Insurance Counseling & Advocacy Program, or HICAP) at 1-800-434-0222.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at: 1-877-588-1123. Information about appealing to the Quality Improvement Organization is also in the “Notice of Medicare Non-Coverage.” This is the notice you got when you were told we would stop covering your care.

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization for your state at 1-877-588-1123 and ask for a “fast-track appeal.”

Call before you leave the agency or facility that is providing your care and before your planned discharge date.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

What should you ask for?

Ask them for a “fast-track appeal.” This is an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization no later than noon of the day after you got the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section H4 on page 211.
- 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 go to Section E4 on page 181 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 Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html

What happens during the Quality Improvement Organization’s review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- When you ask for an appeal, the plan must write a letter to you and the Quality Improvement Organization explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

The legal term for the letter explaining why your services should end is **“Detailed Explanation of Non-Coverage.”**

What happens if the reviewers say Yes?

- If the reviewers say **Yes** to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say No?

- If the reviewers say **No** to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

H3. Level 2 Appeal to continue your care

If the Quality Improvement Organization said **No** to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

During the Level 2 Appeal, the Quality Improvement Organization will take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. You can reach Livanta BFCC-QIO at 1-877-588-1123. Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-877-588-1123 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says No?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please go to Section E4 on page 181 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.

H4. What happens if you miss the deadline for making your Level 1 Appeal

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a “fast review.”
- **If we say Yes** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.
- It also means that 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 review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.

At a glance: How to make a Level 1 Alternate Appeal

Call our Customer Service number and ask for a “fast review.”

We will give you our decision within 72 hours.

If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the “Independent Review Entity.” When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for “fast review” or “fast appeal” is “expedited appeal.”

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section J on page 214 tells how to make a complaint.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your “fast review.” This organization decides whether the decision we made should be changed.

- The IRE does a “fast review” of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal.
- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE says No** to your appeal, it means they agree with us that stopping coverage of services was medically appropriate.

At a glance: How to make a Level 2 Appeal to require that the plan continue your care

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

The letter you get from the IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

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 go to Section E4 on page 181 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.

I. Taking your appeal beyond Level 2

I1. 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 your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the Cal MediConnect Ombuds Program at 1-855-501-3077.

I2. Next steps for Medi-Cal services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medi-Cal. If you do not agree with the State Hearing decision and you want another judge to review it, you may ask for a rehearing and/or seek judicial review.

To ask for a rehearing, mail a written request (a letter) to:

The Rehearing Unit
744 P Street, MS 19-37
Sacramento, CA 95814

This letter must be sent within 30 days after you get your decision. This deadline can be extended up to 180 days if you have a good reason for being late.

In your rehearing request, state the date you got your decision and why a rehearing should be granted. If you want to present additional evidence, describe the additional evidence and explain why it was not introduced before and how it would change the decision. You may contact legal services for assistance.

To ask for judicial review, you must file a petition in Superior Court (under Code of Civil Procedure Section 1094.5) within one year after receiving your decision. File your petition in the Superior Court for the county named in your decision. You may file this petition without asking for a rehearing. No filing fees are required. You may be entitled to reasonable attorney's fees and costs if the Court issues a final decision in your favor.

If a rehearing was heard and you do not agree with the decision from the rehearing, you may seek judicial review but you cannot request another rehearing.

J. How to make a complaint

J1. What kinds of problems should be complaints



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- SCFHP staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Customer Service or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Customer Service or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 217.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

The legal term for a “complaint” is a “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

Are there different types of complaints?

Yes. 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 that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the Cal MediConnect Ombuds Program at 1-855-501-3077.

J2. Internal complaints

To make an internal complaint, call Customer Service at 1-877-723-4795. 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 file it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Customer Service will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- You can use our “Cal MediConnect Member Grievance and Appeal Form” available on our website at www.scfhp.com. All of our plan providers can give you the form or we can mail one to you. You can also file a grievance online. You can give a completed form to our plan provider or send it to us at the address below:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

We will call you or send you a letter within 5 days, letting you know we received your grievance. We will work to resolve the complaint and we may contact you or your provider for more information.

The entire process will be resolved within 30 days. We will send you a letter explaining our decision within this time.

You can make a “fast complaint” if you disagree with our decision not to expedite your request for a coverage decision or appeal, or our decision to extend the timeframe for a coverage decision or appeal. We will respond to your fast complaint within 24 hours from the time that we receive your request.

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. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 30 calendar days. If we do not make a decision within 30 calendar days because we need more information, we will notify you in writing. We will also provide a status update and estimated time for you to get the answer.
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you are making a complaint because we took extra time to make a coverage decision, we will automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- **If we do not agree** with some or all of your complaint, we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx.

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

You can tell Medi-Cal about your complaint

The Cal MediConnect Ombuds Program also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we must provide. The Cal MediConnect Ombuds Program is not connected with us or with any insurance company or health plan.

The phone number for the Cal MediConnect Ombuds Program is 1-855-501-3077. The services are free.

You can tell the California Department of Managed Health Care about your complaint

The California Department of Managed Health Care (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.dmhc.ca.gov).

You can file a complaint with the 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



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr/index.html for more information.

You may also contact the local Office for Civil Rights office at:

Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

Customer Response Center: 1-800-368-1019
Fax: 1-202-619-3818
TDD: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act and under any state laws that may apply. You can contact the Cal MediConnect Ombuds Program for assistance. The phone number is 1-855-501-3077.

You can file a complaint with the Quality Improvement Organization

When your complaint is about quality of care, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (without making the complaint to us).
- Or you can make your complaint to us and to the Quality Improvement Organization. If you make a complaint to this organization, we will 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, see Chapter 2, page 18.

In California, the Quality Improvement Organization is called Livanta BFCC-QIO. The phone number for Livanta BFCC-QIO is 1-877-588-1123.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Chapter 10: Ending your membership in our Cal MediConnect Plan

Introduction

This chapter tells about ways you can end your membership in our Cal MediConnect plan and your health coverage options after you leave the 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 the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



A. When you can end your membership in our Cal MediConnect plan

You can end your membership in SCFHP Cal MediConnect Plan (Medicare-Medicaid Plan) at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Cal MediConnect plan, or moving to Original Medicare.

Your membership will end 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 will end on January 31. Your new coverage will begin the first day of the next month (February 1, in this example).

When you end your membership in our plan, you will continue to be enrolled in SCFHP for your Medi-Cal services, unless you choose a different Cal MediConnect plan or a different Medi-Cal only plan. You can also choose your Medicare enrollment options when you end your membership in our plan. If you leave our plan, you can get information about your:

- Medicare options in the table on page 222.
- Medi-Cal services on page 225.

You can get more information about how you can end your membership by calling:

- Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
- Health Care Options at 1-844-580-7272, Monday through Friday from 8:00 am to 6:00 pm. TTY users should call 1-800-430-7077.
- State Health Insurance Assistance Program (SHIP), 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/.
- Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- 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.

NOTE: If you're in a drug management program, you may not be able to change plans. See Chapter 5, Section G, page 133 for information about drug management programs.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

B. How to end your membership in our Cal MediConnect plan

If you decide to end your membership, tell Medi-Cal or Medicare that you want to leave SCFHP Cal MediConnect:

- 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; OR
- 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 222.

C. How to join a different Cal MediConnect plan

If you want to keep getting your Medicare and Medi-Cal benefits together from a single plan, you can join a different Cal MediConnect plan.

To enroll in a different Cal MediConnect plan:

- 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. Tell them you want to leave SCFHP Cal MediConnect and join a different Cal MediConnect plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with SCFHP Cal MediConnect will end on the last day of the month that we get your request.

D. How to get Medicare and Medi-Cal services separately

If you do not want to enroll in a different Cal MediConnect plan after you leave SCFHP Cal MediConnect, you will go back to getting your Medicare and Medi-Cal services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our Cal MediConnect plan.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

1. You can change to:

A Medicare health plan, such as a Medicare Advantage Plan or, if you meet eligibility requirements and live within the service area, a Program of All-inclusive Care for the Elderly (PACE)

Here is what to do:

Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For PACE inquiries, call 1-855-921-PACE (7223).

If you need help or more information:

- Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.

You will automatically be disenrolled from SCFHP Cal MediConnect when your new plan's coverage begins.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



<p>2. You can change to:</p> <p>Original Medicare with a separate Medicare prescription drug plan</p>	<p>Here is what to do:</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">• Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. <p>You will automatically be disenrolled from SCFHP Cal MediConnect when your Original Medicare coverage begins.</p>
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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

<p>3. You can change to:</p> <p>Original Medicare without a separate Medicare prescription drug plan</p> <p>NOTE: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you do not want to join.</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 www.aging.ca.gov/HICAP/.</p>	<p>Here is what to do:</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"> • Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/. <p>You will automatically be disenrolled from SCFHP Cal MediConnect when your Original Medicare coverage begins.</p>
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D2. How to get your Medi-Cal services

If you leave our Cal MediConnect plan, you will continue to get your Medi-Cal services through SCFHP unless you select a different plan for your Medi-Cal services.

Your Medi-Cal services include most long-term services and supports and behavioral health care.

If you want to choose a different plan for your Medi-Cal services, you need to let Health Care Options know when you ask to end your membership with our Cal MediConnect plan.

- 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. Tell them you want to

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



leave SCFHP Cal MediConnect and join a different Medi-Cal plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

When you end your membership with our Cal MediConnect plan, you will get a new Member ID Card, a new *Member Handbook*, and a new *Provider and Pharmacy Directory* for your Medi-Cal coverage.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you leave SCFHP Cal MediConnect, it may take time before your membership ends and your new Medicare and Medi-Cal coverage begins. See page 221 for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our Cal MediConnect plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership in our Cal MediConnect plan ends

These are the cases when SCFHP Cal MediConnect must end your membership in the 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 for people who qualify for both Medicare and Medi-Cal. To be a member of SCFHP Cal MediConnect, you must keep your eligibility with Medi-Cal and Medicare. The State or Medicare may disenroll you if you are determined no longer eligible for Cal MediConnect.
- 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, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

- 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 will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

If you no longer qualify for Medi-Cal or your circumstances have changed that make you no longer eligible for Cal MediConnect, you may continue to get your benefits from SCFHP Cal MediConnect for an additional two-month period. This additional time will allow you to correct your eligibility information if you believe that you are still eligible. You will get a letter from us about the change in your eligibility with instructions to correct your eligibility information.

- To stay a member of SCFHP Cal MediConnect, you must qualify again by the last day of the two-month period.
- If you do not qualify by the end of the two-month period, you'll be disenrolled from SCFHP Cal MediConnect.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medi-Cal first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our Cal MediConnect plan for any health-related reason

If you feel that you are being asked to leave our plan for a health-related reason, you should call **Medicare** at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



You should also **call the Cal MediConnect Ombuds Program** at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our Cal MediConnect 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 see Chapter 9, Section J, page 214 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can:

- Call Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m..
- 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.
- Call the California Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-434-0222, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local HICAP office in your area, please visit www.aging.ca.gov/HICAP/.
- Call the Cal MediConnect Ombuds Program at 1-855-501-3077, Monday through Friday from 9:00 a.m. to 5:00 p.m. TTY users should call 1-855-847-7914.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in SCFHP Cal MediConnect. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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 this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medi-Cal programs. Other federal and state laws may apply too.

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, or sex. In addition, we don't discriminate or treat you differently because of your ancestry, marital status, or sexual orientation.

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 for more information.
- Call your local Office for Civil Rights at 1-800-368-1019. TDD users call 1-800-537-7697.

If you have a disability and need help accessing health care services or a provider, call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

C. Notice about Medicare as a second payer and Medi-Cal as a payer of last resort

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

The Cal MediConnect program complies with State and Federal laws and regulations relating to the legal liability of third parties for health care services to members. We will

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



take all reasonable measures to ensure that the Medi-Cal program is the payer of last resort.

D. Third Party Liability

You must tell SCFHP if you are injured or sick because of another person's fault or negligence. SCFHP will let the Department of Health Care Services (DHCS) know about your case.

If the cost of services is paid by another source (a "third party"), DHCS may have a right to get the money back from the third party. If DHCS does not recover these costs, SCFHP may do so. DHCS has the right to recover and can ask a third party for money related to services you get from us if:

- You are sick or hurt due to someone else, such as a car accident (third party tort liability)
- You are hurt on the job (worker's compensation)
- There is money owed (estate recovery)

When DHCS has the right to recover due to a third party's action:

- We will give you any medically necessary services at the time the services are needed
- We will let DHCS know about the third party's action if we know about it
- We will ask the third party to pay us back for the services provided
- You will need to help us get the necessary information from the third party so that we can get paid back

Keep in mind:

- If the third party pays you money, you must pay DHCS for services that we paid for or gave to you
- The amount you owe DHCS will never be more than the amount you get from the third party

This agreement extends to services provided under any other state or federal medical care program, or under other contractual or legal entitlement including, but not limited to, any health care services provided as a result of a tort or casualty claim (such as automobile accident or workers' compensation) of a third party. Other coverage is primary and Medi-Cal is payer of last resort.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



E. Statement of Nondiscrimination

Santa Clara Family Health Plan (SCFHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. SCFHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

SCFHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- SCFHP provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Service at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

If you believe that SCFHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Attn: Grievance and Appeals Department
Santa Clara Family Health Plan
6201 San Ignacio Ave
San Jose, CA 95119

Phone: 1-877-723-4795

TTY: 711

Fax: 1-408-874-1962

Email: CalMediConnectGrievances@scfhp.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Customer Service representative is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: 1-800-368-1019
TDD: 1-800-537-7697

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

F. Notice of Privacy Practices

Effective: January 1, 2016

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

In this notice we use the terms “we,” “us,” and “our” to describe Santa Clara Family Health Plan.

Santa Clara Family Health Plan (SCFHP) is required by state and federal law to protect your health information. We also require all contracting providers and vendors to protect

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



your health information. We must give you this notice that tells how we may use and share your information. It also tells you what your rights are.

Your Information is Personal and Private

We get information about you from Federal, State, and local agencies after you are eligible to enroll in our health plan. We also get medical information from your health care providers, clinics, labs, and hospitals so we can approve and pay for your health care.

What is “Protected Health Information”?

Your protected health information (“PHI”) is health information that contains identifiers, such as your name, Social Security number, or other information that reveals who you are. For example, your medical record is PHI because it includes your name and other identifiers.

Our staff follows policies and procedures that protect your health information given to us in oral, written or electronic ways. Our staff goes through training which covers the internal ways members’ oral, written and electronic PHI may be used or disclosed across the organization. All our staff with access to your health information is trained on privacy and information security laws. Staff has access only to the amount of information they need to do their job.

Our employees also follow internal practices, policies and procedure to protect any conversations about your health information. For example, employees are not allowed to speak about your information in the elevator or hallways. Employees must also protect any written or electronic documents containing your health information across the organization.

Our computer systems protect your electronic PHI at all times by using various levels of password protection and software technology. Fax machines, printers, copiers, computer screens, workstations, and portable media disks containing your information are carefully guarded from others who should not have access. Employees must ensure member PHI is picked up from fax machines, printers and copiers and only is received by those who have access. Portable media devices with PHI are encrypted and must have password protections applied. Computer screens must be locked when employees are away from their desks and offices. Workstation drawers and cabinets that contain PHI have secure locks placed on them.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Changes to Notice of Privacy Practices

We must obey the notice that we are using now. We have the right to change these privacy practices. Any changes in our practices will apply to all of your medical information. If we do make changes required by law, we will notify you.

How We May Use and Share Information about You

Your information may be used or shared by us only for treatment, payment and health care operations. Some of the information we use and share is:

- Your name,
- Address,
- Personal facts,
- Medical care given to you,
- The cost of your medical care, and
- Your medical history.

Some actions we take when we act as your health plan include:

- Checking whether you are covered,
- Approving, giving, and paying for services,
- Investigating or prosecuting cases (like fraud),
- Checking the quality of care you receive,
- Making sure you get all the care you need.

Some examples of why we would share your information with others involved in your health care are:

- **For treatment:** You may need medical treatment that needs to be approved ahead of time. We will share information with health care providers, hospitals, and others in order to get you the care you need.
- **For payment:** We use your PHI to pay for health care claims sent to us for your medical care. When we do this, we share information with the health care providers, clinics, and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.
- **For health care operations:** We may use information in your health record to check the quality of the health care you receive. We may also use this

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information in audits, programs to stop fraud and abuse, planning and general administration.

- **For business associates:** We may use or disclose your PHI to an outside company that assists us in operating our health system.

Other Uses for your Health Information

The following is a description of other possible ways in which we might (and are permitted to) use and/or disclose your protected health information:

- We may give out medical information to a health oversight agency for activities authorized by law. These oversight activities may include audits, investigations, inspections and licensure or disciplinary actions. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- You or your physician, hospital, and other health care providers may not agree if we decide not to pay for your care. We may use your health information to review these decisions.
- We may share your health information with groups that check how our health plan is providing services.
- We may share information with persons involved in your health care, or with your personal representative.
- We must share your health information with the federal government when it is checking on how we are meeting privacy rules.
- We may share your health information with organizations that obtain, bank or transplant organs or tissue donations.
- We may share your health information about a worker's compensation illness or injury following written request by your employer, worker's compensation insurer, or their representatives.
- We may use and share your health information for certain kinds of research.
- We may give out your information for public health activities. These activities may include, but are not limited to the following:
 - To prevent or control disease, injury, or disability;
 - To report births and deaths;
 - To report child abuse or neglect;
 - To report problems with medications and other medical products;



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- To notify people of recalls of products they may be using; and
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

When Written Permission is Needed

If we want to use your information for any purposes not listed above, we must get your written permission. If you give us your permission, you may take it back in writing at any time.

What Are Your Privacy Rights?

You have the right to ask us not to use or share your protected health care information. We will send you a form to fill out to tell us what you want. Or, we can fill out the form for you. We may not be able to agree to your request.

You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect your safety.

You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out to tell us what you want copied. You may have to pay for costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

You have the right to ask that information in your records be changed if it is not correct or complete. You will be sent a form to fill out to tell us what changes you want. We may refuse your request if:

- The information is not created or kept by SCFHP, or
- The information is not part of a standard set of information kept by SCFHP, or
- The information has been gathered for a court case or other legal actions, or
- We believe it is correct and complete.

We will let you know if we agree to make the changes you want. If we don't agree to make the changes you want, we will send you a letter telling you why. You may ask that we review our decision if you disagree with it. You may also send a statement saying why you disagree with our records. We will keep your statement with your records.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



Important

Santa Clara Family Health Plan does not have complete copies of your medical records.

If you want to look at, get a copy of, or change your medical records, please contact your physician or clinic.

When we share your health information you have the right to request a list of:

- Whom we shared the information with,
- When we shared it,
- For what reasons, and
- What information was shared.

This list will not include when we share information with you, with your permission, or for treatment, payment, or health plan operations.

You have a right to request a printed paper copy of this Notice of Privacy Practices.

You can also find this notice on our website at www.scfhp.com.

Privacy Breach

Breach of the security of the system means unauthorized acquisition of computerized data that compromises the security, confidentiality, or integrity of a member's personal information maintained by SCFHP. Good faith acquisition of a member's personal information by an employee or agent of SCFHP for the purposes of SCFHP is not a breach of the security of the system, provided that the personal information is not used or subject to further unauthorized disclosure.

Personal information means a member's first name or first initial, and last name, in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted:

- Social Security number;
- driver's license number or California identification card number;
- credit or debit card number, or account number, in combination with any required security code, access code, or password that would permit access to an individual's financial account;
- medical information; or)
- health insurance information.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records. Medical information means any information regarding a member's medical history, mental or physical condition, or medical treatment or diagnosis by a health care professional. Health insurance information means a member's health insurance policy number or subscriber identification number, any unique identifier used by a health insurer to identify the member, or any information in a member's application and claims history, including any appeals records.

In the event that an unauthorized person acquires private health information of SCFHP's members, SCFHP will disclose the breach to the affected members as quickly as possible, without unreasonable delay, consistent with the legitimate needs of law enforcement or any measures necessary to determine the scope of the breach and restore the reasonable integrity of the data system.

The security breach notification to members shall be written in plain language, and include (at a minimum), the name and contact information of the member who is reasonably believed to have been the subject of the breach. If any of the following information is possible to determine at the time the notice is provided, then the notification shall include: the date of the breach; or the estimated date of the breach; or the date range within which the breach occurred. The notification shall also include: the date of the notice; whether the notification was delayed as a result of law enforcement investigation; a general description of the breach incident; and the toll-free telephone numbers and addresses of the major credit reporting agencies, if the breach exposed a Social Security number, a driver's license number, or a California identification card number. At the discretion of SCFHP, the notification may also include: information about what SCFHP has done to protect members whose information has been breached; and/or advice on steps that the member whose information has been breached may take to protect him/herself.

The security breach notification may be provided by one of the following methods:

- written notice;
- electronic notice; or
- substitute notice.

A substitute notice may be used if SCFHP demonstrates that the cost of providing notice would exceed two hundred fifty thousand dollars (\$250,000), or the number of affected members to be notified exceeds 500,000, or when SCFHP does not have sufficient contact information. Substitute notice shall consist of all of the following:

- email notice when SCFHP has an email address for the affected member;

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- conspicuous posting of the notice on SCFHP's internet website; and
- notification to major statewide media and the Office of Information Security within the California Technology Agency.

If the breach affects more than 500 members, SCFHP will send a single sample copy of the security breach notification to the Attorney General (excluding any personally identifiable information).

SCFHP'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS ARE AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

How Do You Contact Us to Use Your Rights?

If you want to use any of the privacy rights explained in this notice, please call or write us at:

Compliance and Privacy Officer
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Toll-free: **1-877-723-4795**
Fax: **1-408-874-1970**
TTY: **711**

Complaints

If you believe that we have not protected your privacy and wish to complain, you may file a complaint (or grievance) by calling or writing us:

Attn: Compliance and Privacy Officer
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

Toll-free: **1-877-723-4795**
Fax: **1-408-874-1970**
TTY: **711**

OR you may contact the agencies below:

Privacy Office Hotline/Office of HIPAA Compliance (OHC)
Phone: **1-916-445-4646**



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

Toll-free: **1-866-866-0602**

Email: privacyofficer@dhcs.ca.gov

Attn: Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
90 7th St, Ste 4-100
San Francisco, CA 94103
Customer Response Center: **1-800-368-1019**
Fax: **1-202-619-3818**
TDD: **1-800-537-7697**
Email: ocrmail@hhs.gov

Use Your Rights Without Fear

We cannot take away your health care benefits or do anything to hurt you in any way if you file a complaint or use any of the privacy rights in this notice.

Questions

If you have any questions about this notice and want further information, please contact the SCFHP Privacy Officer at the address and phone number above. To get a copy of this notice in other languages, braille, large print, or audio, please call or write the SCFHP Privacy Officer at the number or address listed on page 240.

G.Fraud, waste, and abuse

Health care fraud is a serious issue. Fraud makes health care cost more for everyone. Some forms of health care fraud and abuse can endanger your health, safety, and well-being. You can help stop this waste and abuse.

G1. Health Care Fraud

- Health care fraud is a dishonest act done on purpose. Examples are:
 - Letting someone else use your member ID card.
 - Using false information to get medical services or benefits.
 - Getting prescriptions to abuse drugs or sell drugs.
 - Visiting different doctors to get multiple prescriptions for the same drug.
 - Having a provider bill you for services you didn't get.

Committing fraud is a crime. Visit www.stopmedicarefraud.gov for more information.

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



- **Protect yourself from fraud.** Anyone can commit fraud, including:
 - Members or their caregivers
 - Medical equipment suppliers
 - Hospital employees
 - Billing services
 - Doctors
- How to protect yourself from fraud:
 - Never let someone else use your member ID card.
 - Know who has access to your information, such as a caregiver or relative.
 - Ask your doctors exactly what tests or procedures they want you to have before you have them. And ask them why you need the tests.
 - Track all doctor visits and appointments you attend, miss, or cancel.
 - If you get bills or claims statements for any services, review them and make sure they are correct. (Note: You should not receive bills for benefits covered by Medi-Cal or Cal MediConnect.)
 - If something is confusing or doesn't look right on your medical and/or prescription drug Explanation of Benefits (EOB), please call us at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m.
 - Beware of "free" medical services.
 - Be careful of anyone who asks for your member ID number, personal identification information, or medical history.
 - If using a computer, completely log out of all password-protected accounts.
- Notify us immediately if:
 - Your card is lost or stolen.
 - A statement shows services, providers, or dates of service that are not correct. (Note: You should not receive bills for benefits covered by Medi-Cal or Cal MediConnect.)

If there is a difference between your records and the doctor's records, it's not always fraud. It could be a simple error. Call us about the difference so we can review it.

G2. How to report fraud, waste, and abuse

Reporting fraud is everyone's responsibility. SCFHP takes fraud, waste, and abuse very seriously. If you suspect fraud, contact our Fraud Hotline as soon as possible. The more



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

information you provide, the better the chance the case is successfully reviewed and resolved.

All calls to the SCFHP Fraud Hotline are anonymous and confidential.

- SCFHP Fraud Hotline:

Phone: 1-408-874-1450, call 24/7.

TTY: 711

Email: ReportFraud@scfhp.com

Fax: 1-408-874-1970

Attn: Compliance Officer
Santa Clara Family Health Plan
PO Box 18880
San Jose, CA 95158

You may also contact the federal agencies below:

- California Department of Health Care Services (DHCS)

Phone: 1-800-822-6222

Email: stopmedicalfraud@dhcs.ca.gov

Web: Report Fraud Online

PAU MS 2200
PO Box 997413
Sacramento, CA 95899-7413

- HHS Office of Inspector General

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Web: Report Fraud Online

HHS Tips Hotline
P.O. Box 23489
Washington, DC 20026-3489

- Centers for Medicare & Medicaid Services

Phone: 1-800-633-4227

TTY: 1-877-486-2048

Web: www.stopmedicarefraud.gov

Report Fraud Online: www.cms.gov/Medicare-Medicaid-Coordination/

If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.



[Fraud-Prevention/FraudAbuseforConsumers/
Report Fraud and Suspected Fraud.html](#)

Medicare Beneficiary Contact Center
P.O. Box 39
Lawrence, KS 66044

H. Affirmative Statement about Incentives

Santa Clara Family Health Plan affirms that:

- Utilization Management (UM) decision-making is based only on appropriateness of care and services and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
- Incentives, including compensation, for any person are not based on the quantity or type of denial decisions rendered.

For questions regarding this statement please call the Utilization Management Department at 1-408-874-1821.

I. How Santa Clara Family Health Plan (SCFHP) evaluates New Technology

Each year, SCFHP looks for changes and advances in health care that may improve your care. We study new treatments, medicines, procedures, and devices. We refer to this as “new technology.”

To consider the use of any new technology, we look at related scientific reports and other information from the government and medical specialists. We also consider value, how well it works, and safety standards. After careful review, we then decide if the new technology should be covered as a health benefit. Members and providers may submit requests directly to SCFHP to review new technology.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

J. Quality Improvement

Quality is important to us, and that's why SCFHP has a strong Quality Improvement Program. The purpose of the program is to make sure we constantly improve quality, safety, and satisfaction of care for all of our members.

The Quality Improvement process helps to:

- Identify areas that need improvement for member care and customer service,
- Set priorities for review, and
- Develop effective ways to address the areas to ensure improvement.

SCFHP identifies areas that need improvement through the following methods:

- Potential Quality Issues (PQI)
- Grievances and Appeals
- Quality Improvement Projects (QIP)
- Consumer Advisory Board (CAB) – See below for more information.
- Health Outcomes Survey (HOS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey
- Healthcare Effectiveness Data and Information Set (HEDIS) metrics
- Facility Site Reviews (FSR)
- Peer Reviews
- Provider Access and Availability Standards

SCFHP has a group called the Consumer Advisory Board (CAB). This group is made up of members, their family members, and/or other caregivers and representatives of community based organizations. The group talks about how to improve SCFHP policies and is responsible for:

- Providing feedback on services, benefits, providers, issues and ways to improve program management
- Providing feedback on events, activities, communication and member materials
- Participating in quality management programs
- Helping SCFHP find gaps in the health care of members, including members using Long-Term Services and Supports (LTSS) and members with other special needs

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If you would like to be a part of this group, call SCFHP Customer Service.

To learn more about the SCFHP's Quality Improvement Program, read the Quality Improvement Program Description available on our website at www.scfhp.com.



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Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Customer Service.

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.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about a Level 1 Appeal or a State Hearing (See Chapter 9, page 165 for more information). This continued coverage is called "aid paid pending."

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, page 165 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.

Cal MediConnect: A program that provides both your Medicare and Medi-Cal benefits together in one health plan. You have one Member ID Card for all your benefits.

Care plan: See "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: See "Interdisciplinary Care Team."



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Case manager (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.

Catastrophic coverage stage: The stage in the Part D drug benefit where the plan pays all of the costs of your drugs until the end of the year. You begin this stage when you have reached the \$6,550 limit for your prescription drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, page 18 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 enrollees who meet applicable eligibility criteria.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance.”

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Copay: A fixed amount you pay as your share of the cost each time you get certain prescription drugs. For example, you might pay \$2 or \$5 for a prescription drug.

Cost sharing: Amounts you have to pay when you get certain services or prescription drugs. Cost sharing includes copays.

Cost sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of four cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, page 165 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.



If you have questions, please call Santa Clara Family Health Plan at 1-877-723-4795 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. The call is free. **For more information**, visit www.scfhp.com.

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 covered by our plan.

Customer Service: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, page 18 for information about how to contact Customer Service.

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.

Daily cost sharing rate: A rate that may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copay. A daily cost sharing rate is the copay divided by the number of days in a month's supply.

Here is an example: Let's say the copay for your drug for a full month's supply (a 31-day supply) is \$3.90. This means that the amount you pay for your drug is \$0.12 per day. If you get a 7 days' supply of the drug, your payment will be \$0.12 per day multiplied by 7 days, for a total payment of \$0.88.

Department of Health Care Services (DHCS): The State department in California that administers the Medicaid Program (referred to as Medi-Cal in California), generally referred to as "the State" in this handbook.

Department of Managed Health Care (DMHC): The State department in California that is responsible for regulating health plans. The DMHC helps people in Cal MediConnect with appeals and complaints about Medi-Cal services. The 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).

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of four tiers.

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, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

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Emergency: A medical emergency is 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 function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are 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 that is 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 that is 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 is 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, page 18 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 case managers to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient’s medical history and current condition. It is used to figure out the patient’s health and how it might change in the future.

Home health aide: A person who provides services that do not 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 do not 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.



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- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- SCFHP Cal MediConnect must give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your SCFHP Cal MediConnect Member ID Card when you get any services or prescriptions. Call Customer Service if you get any bills you do not understand.

Because SCFHP Cal MediConnect pays the entire cost for your medical 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 file an appeal with us. 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 is decided 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.

Initial coverage stage: The stage before your total Part D drug expenses reach \$6,550. This includes amounts you have paid, what our plan has paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays part of the costs of your drugs, and you pay your share.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might 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 will also help you make a care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs covered by the plan. The plan chooses 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."

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Long-term services and supports (LTSS): Long-term services and supports are services that 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 Multipurpose Senior Services Program (MSSP), Community-Based Adult Services (CBAS), and Nursing Facilities/Sub-Acute Care Facilities (NF/SCF).

Low-income subsidy (LIS): See “Extra Help.”

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.

- It helps people with limited incomes and resources pay for long-term services and supports and medical costs.
- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medi-Cal.
- See Chapter 2, page 18 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 means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

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 (see “Health plan”).

Medicare Advantage Plan: A Medicare program, also known as “Medicare Part C” or “MA Plans,” that offers 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 that are covered by Medicare Part A and Part B.



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Medicare-Medi-Cal enrollee (Dual Eligible): 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.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like 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 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. SCFHP Cal MediConnect includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medi-Cal may cover some of these drugs.

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.

Multipurpose Senior Services Program (MSSP): A program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 years or older with disabilities as an alternative to nursing facility placement.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health

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agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are 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 cannot get their care at home but who do not 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 about the Cal MediConnect Ombuds Program in Chapter Chapters 2, page 18 and 9, page 165 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can see 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 do not 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. Most drugs you get from out of network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered



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services to members of our plan. Chapter 3, page 43 explains out-of-network providers or facilities.

Out-of-pocket costs: The cost sharing requirement for members to pay for part of the services or drugs they get is also called the “out-of-pocket” cost requirement. See the definition for “cost sharing” above.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a health care professional.

Part A: See “Medicare Part A.”

Part B: See “Medicare Part B.”

Part C: See “Medicare Part C.”

Part D: See “Medicare Part D.”

Part D drugs: See “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. See SCFHP’s Notice of Privacy Practices for more information about how SCFHP protects, uses, and discloses your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy.

- He or she also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must see your primary care provider before you see any other health care provider.
- See Chapter 3, page 43 for information about getting care from primary care providers.

Prior authorization: An approval from SCFHP Cal MediConnect you must get before you can get a specific service or drug or see an out-of-network provider. SCFHP Cal MediConnect may not cover the service or drug if you don’t get approval.

Some network medical services are covered only if your doctor or other network provider gets prior authorization from our plan.

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- Covered services that need our plan's prior authorization are marked in the Benefits Chart in Chapter 4, page 63.

Some drugs are covered 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) Plans: 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.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items 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. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, page 18 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can see someone that is not your PCP. If you don't get approval, SCFHP Cal MediConnect may not cover the services. You don't need a referral to see certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3, page 43 and about services that require referrals in Chapter 4, page 63.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4, page 63 to learn more about rehabilitation services.

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 is also generally the area where you can get routine (non-emergency) services. Only the people who live in our service area can get SCFHP Cal MediConnect.



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Share of cost: The portion of your health care costs that you may have to pay each month before Cal MediConnect benefits become effective. The amount of your share of cost varies depending on your income and resources.

Silver&Fit® (fitness benefit provider): The Silver&Fit® program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). Silver&Fit and ASHConnect are trademarks of ASH and used with permission herein. Go to www.silverandfit.com or call Silver&Fit® Customer Service at 1-877-427-4788, Monday through Friday, 5 a.m. to 6 p.m. PST. See Chapter 4, Section D, Page 79.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Hearing: If your doctor or other provider asks for a Medi-Cal service that we will not approve, or we will not 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 first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security 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.

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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