CareAdvantage by HealthPlan OF SAN MATEO

Summary of Benefits

CareAdvantage

Dual Eligible Special Needs Plan (D-SNP)

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Last Updated 09/13/2023

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Our CareAdvantage Unit Is Available to Help You

Call us at **1-866-880-0606** (toll free) or **650-616-2174.**
Hearing Impaired: TTY **1-800-735-2929** or dial **7-1-1.**

- Call Center Hours are Monday through Sunday 8:00 a.m. to 8:00 p.m.
- Office Hours are Monday through Friday 8:00 a.m. to 5:00 p.m.

Large-print Request: If you would like a large-print copy of this book, please call the CareAdvantage Unit.

Privacy Statement: Health Plan of San Mateo ensures the privacy of your medical record. For questions and more information, please call the CareAdvantage Unit.

Nuestro Departamento de CareAdvantage está a su disposición para ayudarle

Llámenos al **1-866-880-0606** (número telefónico gratuito) o al **650-616-2174**.
Miembros con dificultades auditivas: TTY **1-800-855-3000** o marque el **7-1-1.**

- El horario de nuestro centro de atención telefónica es de lunes a domingo, de 8:00 a.m. a 8:00 p.m.
- El horario de oficina es de lunes a viernes, de 8:00 a.m. a 5:00 p.m.

Solicitud de impresión en caracteres grandes: Si desea un ejemplar de este manual en letra grande, por favor llame al Departamento de CareAdvantage.

Declaración de privacidad: Health Plan of San Mateo asegura la privacidad de su expediente médico. Si tiene alguna pregunta o desea obtener más información, por favor llame al Departamento de CareAdvantage.

我們的 CareAdvantage Unit 為您提供協助

請撥打我們的電話**1-866-880-0606**(免費)或
650-616-2174. 有聽力障礙者: TTY **1-800-735-2929** 或撥 **7-1-1.**

- 電話中心服務時間是週一至週日上午8:00 至晚上 8:00。
- 辦公室的服務時間是週一至週五上午 8:00 至下午 5:00。

大字版需求: 若需要本手冊的大字版，請致電與 CareAdvantage Unit 聯絡。

隱私權聲明: 聖馬刁健康計劃 (HPSM) 致力保障您的病歷穩私權。
如有疑問且需要更多資訊，請致電與 CareAdvantage Unit 聯絡。

Handa kayong Tulungan ng aming Yunit para sa mga Serbisyo sa mga Miyembro

Tawagan kami sa **1-866-880-0606** (walang bayad) o sa **650-616-2174**.
May Kapansanan sa Pandinig: TTY **1-800-735-2929** o i-dial ang **7-1-1.**

- Bukas ang aming mga call center mula Lunes hanggang Linggo, 8:00 a.m. hanggang 8:00 p.m.
- Bukas ang aming opisina mula Lunes hanggang Biyernes, 8:00 a.m. hanggang 5:00 p.m.

Humiling ng Libro na Malalaki ang Pagkakalimbag ng mga Letra: Kung gusto ninyong makakuha ng librong ito na malalaki ang mga letra sa pagkakalimbag, pakitawagan ang Yunit ng CareAdvantage.

Pahayag sa Pagiging Pribadong ng Impormasyon: Tinitiyak ng Health Plan of San Mateo ang pagiging pribado ng inyong medikal na rekord. Para sa karagdagang katanungan at impormasyon, pakitawagan ang Mga Serbisyo para sa mga Miyembro.

Сотрудники нашего подразделения CareAdvantage Unit готовы вам помочь

Звоните нам по номеру**1-866-880-0606** (бесплатно) или по номеру **650-616-2174**. Для участников с нарушением слуха: телетайп (TTY) **1-800-735-2929** или **7-1-1.**

- Наш центр обработки звонков работает с 8:00 до 20:00 без выходных.
- Наши часы работы: с 8:00 до 17:00 с понедельника по пятницу.

Если нужен крупный шрифт: Если вы хотели бы получить экземпляр данного справочника, набранный крупным шрифтом, позвоните в подразделение CareAdvantage Unit.

Заявление о соблюдении конфиденциальности: Health Plan of San Mateo гарантирует обеспечение конфиденциальности вашей медицинской документации. Если у вас возникли вопросы или вам требуется дополнительная информация, позвоните в подразделение CareAdvantage Unit.

CareAdvantage Dual Eligible Special Needs Plan (D-SNP), a Medicare Medi-Cal Plan | 2024 Summary of Benefits

Introduction

This document is a brief summary of the benefits and services covered by CareAdvantage. It includes answers to frequently asked questions, important contact information, an overview of benefits and services offered, and information about your rights as a member of CareAdvantage. Key terms and their definitions appear in alphabetical order in the last chapter of the *Evidence of Coverage (Member Handbook).*

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A. Disclaimers

This is a summary of health services covered by CareAdvantage for 2024. This is only a summary. Please read the Evidence of Coverage and *Evidence of Coverage (Member Handbook)* for the full list of benefits. *You can ask for an Evidence of Coverage (Member Handbook) by calling the CareAdvantage Unit at the number at the bottom of this page to get one. You can also refer to the Evidence of Coverage and Evidence of Coverage (Member Handbook) on our website www.hpsm.org/careadvantage or download it.*

- CareAdvantage Dual Eligible Special Needs Plan (D-SNP) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Enrollment in CareAdvantage depends on contract renewal.
- For more information about **Medicare**, you can read the *Medicare & You* handbook. It has a summary of Medicare benefits, rights, and protections and answers to the most frequently asked questions about Medicare. 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. For more information about **Medi-Cal**, you can check the California Department of Healthcare Services (DHCS) website (www.dhcs.ca.gov/) or contact the Medi-Cal Office of the Ombudsman 1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m. You can also call the special Ombudsman for people who have both Medicare and Medi-Cal, at 1-855-501-3077, Monday through Friday, between 9:00 a.m. and 5:00 p.m.
- This document is available for free in English, Spanish, Chinese and Tagalog.
- You can get this document for free in other formats, such as large print, braille, or audio. Call 1-866-880-0606, TTY 1-800-735-2929 or dial 7-1-1, Monday through Sunday, 8:00 a.m. to 8:00 p.m.. The call is free.
- To obtain materials in a language other than English and/or in an alternative format now and in the future, call the CareAdvantage Unit at 1-866-880-0606, TTY 1-800-735-2929 or dial 7-1-1. Monday through Sunday, 8:00 a.m. to 8:00 p.m. The call is free. Or by email customersupport@hpsm.org. Or send a request in writing to:

  Health Plan of San Mateo
  CareAdvantage Unit
  801 Gateway Blvd., Suite 100
  South San Francisco, CA 94080.

- Your preferred language and format will be kept on file for future mailings, so you do not need to make a request each time. To change or cancel your preferences, please contact the CareAdvantage Unit.
- All member materials are available online at www.hpsm.org/member/resources.
- If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-866-880-0606, TTY 1-800-735-2929 or dial 7-1-1, Monday through Sunday, 8:00 a.m. to 8:00 p.m. The call is free.
- Si usted habla español, dispone de servicios de asistencia de idioma sin cargo. Llame al 1-866-880-0606, TTY 1-800-855-3000, o marque 7-1-1, de lunes a domingo, de 8:00 a.m. a 8:00 p.m. La llamada es gratuita.
- Puede obtener esta información de forma gratuita en otros formatos, como en letra grande, Braille o audio. Llame al Departamento de CareAdvantage al 1-866-880-0606, de lunes a domingo, de 8:00 a.m. a 8:00 p.m. Los usuarios de TTY deben llamar al 1-800-855-3000 o marcar 7-1-1. La llamada es gratuita.
- 如果您說中文，我們可免費提供語言協助服務。請致電 1-866-880-0606、TTY (聽力及語言障礙) 專線 1-800-735-2929 或撥 7-1-1，服務時間為週一至週日上午 8:00 至晚上 8:00；該電話為免費服務。
- 您可以免費以其他形式取得本資訊，如大號字體、 盲人用點字或錄音。致電 CareAdvantage Unit，電話是 1-866-880-0606，服務時間為週一至週日上午 8:00 至晚上 8:00。有聽力或語言障礙者應撥打 TTY 電話 1-800-735-2929 或 7-1-1。該電話為免費電話服務。
- Kung nagsasalita kayo ng Tagalog, may mga paglilingkod para sa pagtulong sa wika, nang libre na makakamit ninyo. Tumawag sa 1-866-880-0606 (para sa TTY tumawag sa 1-800-735-2929 o i-dial ang 7-1-1, Lunes hanggang Linggo, 8:00 a.m. hanggang 8:00 p.m. Libre ang tawag.
- Maaari mong makuha nang libre ang impormasyong ito sa iba pang anyo, kagaya ng malalaking letra, braille, o audio. Tawagan ang Yunit ng CareAdvantage sa 1-866-880-0606, Lunes hanggang Linggo, mula 8:00 a.m.hanggang 8:00 p.m. Ang mga gumagamit ng TTY ay dapat tumawag sa 1-800-735-2929 o i-dial ang 7-1-1. Libre ang tawag.

B. Frequently asked questions (FAQ)

The following table lists frequently asked questions.

Frequently Asked Questions	Answers
What is a Medicare-Medi-Cal Coordination Plan?	A Medicare-Medi-Cal Coordination Plan is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. It is for people age 65 and older. A Medicare-Medi-Cal Coordination Plan is an organization made up of doctors, hospitals, pharmacies, providers of Long-term Services and Supports (LTSS), and other providers. It also has Care Managers to help you manage all your providers and services and supports. They all work together to provide the care you need.
Will I get the same Medicare and Medi-Cal benefits in CareAdvantage that I get now?	You will get most of your covered Medicare and Medi-Cal benefits directly from CareAdvantage. You will work with a team of providers who will help determine what services will best meet your needs. This means that some of the services you get now may change based on your needs, and your doctor and care team's assessment. You may also get other benefits outside of your health plan the same way you do now, directly from a State or county agency like In-Home Support Services (IHSS), specialty mental health and substance use disorder services, or regional center services. When you enroll in CareAdvantage, you and your care team will work together to develop a care plan to address your health and support needs, reflecting your personal preferences and goals. If you are taking any Medicare Part D prescription drugs that CareAdvantage does not normally cover, you can get a temporary supply and we will help you to transition to another drug or get an exception for CareAdvantage to cover your drug if medically necessary. For more information, call the CareAdvantage Unit at the numbers listed at the bottom of this page.
Can I go to the same doctors I use now?	Often that is the case. If your providers (including doctors, hospitals, therapists, pharmacies, and other health care providers) work with CareAdvantage and have a contract with us, you can keep going to them.

Frequently Asked Questions	Answers

	• Providers with an agreement with us are “in-network.” Network providers participate in our plan. That means they accept members of our plan and provide services our plan covers. **You must use the providers in CareAdvantage’s network.** If you use providers or pharmacies that are not in our network, the plan may not pay for these services or drugs.
	• If you need urgent or emergency care or out-of-area dialysis services, you can use providers outside of CareAdvantage’ s plan.
	• If you are currently under treatment with a provider that is out of CareAdvantage’ s network, or have an established relationship with a provider that is out of CareAdvantage’ s network, call the CareAdvantage Unit to check about staying connected and ask for continuity of care.
	• If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If your doctors are not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:
	  ○ You, your representative, or your provider asks us to let you keep using your current provider.
	  ○ We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say “existing relationship,” it means that you saw an out-of-network provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.

Frequently Asked Questions	Answers
	▪ We determine an existing relationship by reviewing your available health information available or information you give us. ▪ We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. ▪ You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request. ▪ Note: You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services not included in our plan. You cannot make this request for providers of DME, transportation or other ancillary providers. Note: You can only make this request for services of Durable Medical Equipment (DME), transportation, or other ancillary services not included in our plan. You cannot make this request for providers of DME, transportation or other ancillary providers. After the continuity of care period ends, you will need to use doctors and other providers in the CareAdvantage network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to the CareAdvantage *Evidence of Coverage (Member Handbook)* Chapter 1 for more details. To find out if your doctors are in the plan's network, call the CareAdvantage Unit at the numbers listed at the bottom of this page or read CareAdvantage' s *Provider Directory* on the plan's website at www.hpsm.org/careadvantage. If CareAdvantage is new for you, we will work with you to develop care plan to address your needs.

Frequently Asked Questions	Answers
What is a CareAdvantage Care Manager?	A CareAdvantage Care Manager is one main person for you to contact. This person helps to manage all your providers and services and make sure you get what you need.
What are Long-term Services and Supports (LTSS)?	Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine. Most of these services are provided at your home or in your community but could be provided in a nursing home or hospital. In some cases, a county or other agency may administer these services, and your Care Manager or care team will work with that agency.
What is a Multipurpose Senior Services Program (MSSP)?	A MSSP provides on-going care coordination with health care providers beyond what your health plan already provides, and can connect you to other needed community services and resources. This program helps you get services that help you live independently in your home.
What happens if I need a service but no one in CareAdvantage's network can provide it?	Most services will be provided by our network providers. If you need a service that cannot be provided within our network, CareAdvantage will pay for the cost of an out-of-network provider.
Where is CareAdvantage available?	The service area for this plan includes: San Mateo County, California. You must live in this area to join the plan.

Frequently Asked Questions	Answers
What is prior authorization?	Prior authorization means an approval from CareAdvantage to seek services outside of our network or to get services not routinely covered by our network **before** you get the services. CareAdvantage may not cover the service, procedure, item, or drug if you don't get prior authorization. **If you need urgent or emergency care or out-of-area dialysis services, you don't need to get prior authorization first**. CareAdvantage can provide you or your provider with a list of services or procedures that require you to get prior authorization from CareAdvantage before the service is provided. If you have questions about whether prior authorization is required for specific services, procedures, items, or drugs, call the CareAdvantage Unit at the numbers listed at the bottom of this page for help.
What is a referral?	A referral means that your primary care provider (PCP) must give you approval to go to someone that is not your PCP. A referral is different than a prior authorization. If you don't get a referral from your PCP, CareAdvantage may not cover the services. CareAdvantage can provide you with a list of services that require you to get a referral from your PCP before the service is provided. Refer to the *Evidence of Coverage (Member Handbook)* to learn more about when you will need to get a referral from your PCP.
Do I pay a monthly amount (also called a premium) under CareAdvantage?	No. Because you have Medi-Cal, you will not pay any monthly premiums, including your Medicare Part B premium, for your health coverage.
Do I pay a deductible as a member of CareAdvantage?	No. You do not pay deductibles in CareAdvantage.

Frequently Asked Questions	Answers
What is the maximum out-of-pocket amount that I will pay for medical services as a member of CareAdvantage?	There is no cost sharing for medical services in CareAdvantage, so your annual out-of-pocket costs will be $0.
Do I have a coverage gap for drugs?	No. Because you have Medicaid you will not have a coverage gap stage for your drugs.

C. List of covered services

The following table is a quick overview of what services you may need, your costs, and rules about the benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need hospital care	Hospital stay	$0	Our Plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan you are going to be admitted to the hospital.
	Doctor or surgeon care	$0	Prior authorization is required (inpatient level of care).
	Outpatient hospital services, including observation	$0	Prior authorization maybe required depending on the type of service/procedure.
	Ambulatory surgical center (ASC) services	$0	Prior authorization maybe required depending on the type of service/procedure.
You want a doctor (continued on the next page)	Visits to treat an injury or illness	$0	Prior authorization is required for some services.
	Specialist care	$0	A referral from your primary care provider (PCP) is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You want a doctor (continued)	Wellness visits, such as a physical	$0	One wellness visit, such as a physical, once every 12 months.
	Care to keep you from getting sick, such as flu shots and screenings to check for cancer	$0	Vaccines, including flu shots (once each flu season in the fall and winter), Hepatitis B shots if you are high or intermediate risk of getting hepatitis B, COVID-19 vaccine, pneumonia vaccines and other vaccines if you are at risk that meet Medicare Part B coverage rules. Refer to the CareAdvantage *Evidence of Coverage (Member Handbook)* Chapter 4 for more details.
	"Welcome to Medicare" (preventative visit one time only)	$0	You can get a "Welcome to Medicare" preventive visit once within 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.
You need emergency care (continued on the next page)	Emergency room services	$0	Emergency room services are covered in and out of network without prior authorization. You are only covered for emergency services outside of the United States and its territories if you are admitted to a hospital in Canada or Mexico.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need emergency care (continued)	Urgent care	$0	Urgent Care is covered in and out of network without prior authorization. You are NOT covered for Urgent Care services outside of the United States.
You need medical tests	Diagnostic radiology services (for example, X-rays or other imaging services, such as CAT scans or MRIs)	$0	Referral is required, except for X-rays. Prior authorization required for: • Diagnostic radiology services (MRIs, CT scans) Therapeutic radiology services (such as radiation treatment for cancer)
	Lab tests and diagnostic procedures, such as blood work	$0	Prior authorization is required for some services provided during a non-covered inpatient stay.
You need hearing/auditory services	Hearing screenings	$0	Referral is required
	Hearing aids	$0	Referral is required. Prior authorization is required. Hearing aid benefit is $1,510 per fiscal year (July 1–June 30) for both ears, and includes molds, modification supplies and accessories.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need dental care	Dental check-ups and preventive care	$0	Services that are covered under the HPSM Dental Program, are not chargeable to you. However, you are responsible for your share of the cost amount, if applicable. You are responsible for paying for services not covered by your plan or by the HPSM Dental Program. For more information, visit www.hpsm.org/dental or see Chapter 4 Section E of CareAdvantage *Evidence of Coverage (Member Handbook)*.
	Restorative and emergency dental care	$0	Services that are covered under the HPSM Dental Program, are not chargeable to you. However, you are responsible for your share of the cost amount, if applicable. You are responsible for paying for services not covered by your plan or by the HPSM Dental Program. For more information, visit www.hpsm.org/dental or see Chapter 4 Section E of CareAdvantage *Evidence of Coverage (Member Handbook)*.
You need eye care (continued on the next page)	Eye exams	$0	Exam to diagnose and treat diseases of the eye (including yearly glaucoma screening) Routine eye exam (up to 1 every year)

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need eye care (continued)	Glasses or contact lenses	$0	Up to $175 every year for • eyeglasses (frames and lenses) or contact lenses
	Other vision care	$0	
You need mental health services (continued on the next page)	Mental health services	$0	Screening by BHRS is required for: • outpatient group therapy visit • outpatient individual therapy visit • outpatient individual therapy visit with a psychiatrist • outpatient group therapy visit with a psychiatrist • partial hospitalization program services Mental health services are offered by HPSM and San Mateo County Behavioral Health and Recovery Services (BHRS), according to symptoms and need. You can call the BHRS ACCESS Call Center at 1-800-686-0101 (TTY dial 7-1-1) for more information.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need mental health services (continued)	Inpatient and outpatient care and community-based services for people who need mental health services	$0	Prior authorization from BHRS is required. Our plan covers up to 190 days for inpatient mental health care in a psychiatric hospital. The inpatient hospital limitation does not apply to inpatient mental health services provided in a general hospital. After 190 days, the local county mental health agency will coordinate authorization and pay for inpatient psychiatric services. Long-term mental health services are offered through San Mateo County Behavioral Health and Recovery Services (BHRS). You can call the BHRS ACCESS Call Center at 1-800-686-0101 (TTY dial 7-1-1) for more information.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a substance use disorder services	Substance use disorder services	$0	Referral is required for outpatient substance use services. Prior authorization from BHRS is required for: • outpatient substance use group therapy visit • outpatient substance use individual therapy visit Substance use services are offered through San Mateo County Behavioral Health and Recovery Services (BHRS). You can call the BHRS ACCESS Call Center at 1-800-686-0101 (TTY dial 7-1-1 for more information.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need a place to live with people available to help you	Skilled nursing care	$0	Prior authorization is required. Our plan covers an unlimited number of days in a skilled nursing facility (SNF).
	Nursing home care	$0	Referral required. Authorization from your PCP is required if you are hospitalized less than 3 days before admission to a SNF.
	Adult Foster Care and Group Adult Foster Care	$0	
You need therapy after a stroke or accident	Occupational, physical, or speech therapy	$0	Referral is required. Prior authorization is required. Beneficiary must meet eligibility criteria to receive non-Medicare occupational, speech or physical therapy.
You need help getting to health services (continued on the next page)	Ambulance services	$0	In case of emergency, dial 9-1-1.
	Emergency transportation	$0	In case of emergency, dial 9-1-1.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help getting to health services (continued)	Transportation to medical appointments and services	$0	Non-Medical Transportation (NMT). This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation. 0 copay for trips to covered services. We have contracted with American Logistics Company (ALC) to offer this service. To schedule a ride, please call ALC at **1-877-356-1080**, Monday through Friday, 8:00 a.m. to 5:00 p.m., at least **two (2) business days before your appointment**. If you have an unexpected service, call ALC to reserve your ride as soon as possible. Limitations apply. Prior authorization by ALC is required. Non-Emergency Medical Transportation (NEMT). This benefit includes ambulance, litter/gurney van and wheelchair van medical transportation for non-emergency care. HPSM requires prior authorization of NEMT services. Read the *Evidence of Coverage (Member Handbook)* Chapter 4 for more information.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued on the next page)	Medicare Part B prescription drugs	$0	Part B drugs include drugs given by your doctor in their office, some oral cancer drugs, and some drugs used with certain medical equipment. Read the *Evidence of Coverage (Member Handbook)* for more information on these drugs.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Generic drugs (no brand name)	You pay $0, $1.55 or $4.5 for a *30-day* supply. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	There may be limitations on the types of drugs covered. Please refer to CareAdvantage's *List of Covered Drugs (Drug List/Formulary)* for more information. Once you or others on your behalf pay $8,000 you have reached the catastrophic coverage stage and you pay $0 for all your Medicare drugs. Read the *Evidence of Coverage (Member Handbook)* for more information on this stage. You can get a 30- or 90-day supply of these drugs at any in-network retail or mail order your pharmacy. Your copay will be the same. **Important Message About What You Pay for Vaccines** – Some vaccines are considered medical benefits. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Drug List/Formulary)*. Our plan covers most Part D vaccines at no cost to you.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need drugs to treat your illness or condition (continued)	Brand name drugs	You pay $0, $4.60, or $11.20 for a *30-day* supply. Copays for prescription drugs may vary based on the level of Extra Help you get. Please contact the plan for more details.	There may be limitations on the types of drugs covered. Please refer to CareAdvantage' s *List of Covered Drugs (Drug List/Formulary)* for more information. You can get a 30 or 90-day supply of these drugs at your pharmacy. Your copay will be the same.
	Over-the-counter (OTC) items and drugs	$0	There may be limitations on the types of drugs covered. Please refer to CareAdvantage' s *List of Covered Drugs (Drug List/Formulary)* for more information.
You need help getting better or have special health needs	Rehabilitation services	$0	Prior authorization is required.
	Medical equipment for home care	$0	Our plan has preferred vendors/manufacturers for durable medical equipment (DME). Contact the CareAdvantage Unit for more information. Referral is required. Prior authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
	Dialysis services	$0	Outpatient dialysis treatment, including dialysis services when temporarily out of the plan's service area or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.
You need foot care	Podiatry services	$0	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.
	Orthotic services	$0	Orthotics are covered when medically necessary. Prior authorization may be required. Coverage is based on Medicare rules.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need durable medical equipment (DME) **Note:** This is not a complete list of covered DME. For a complete list, contact the CareAdvantage Unit or refer to Chapter 4 of the *Evidence of Coverage (Member Handbook)*.	Wheelchairs, crutches, and walkers	$0	Our plan has preferred vendors/manufacturers for durable medical equipment (DME). Contact the CareAdvantage Unit for more information. A referral is required for DME used outside of the home. Prior authorization is required.
	Nebulizers	$0	Our plan has preferred vendors/manufacturers for durable medical equipment (DME). Contact the CareAdvantage Unit for more information. A referral is required for DME used outside of the home. Prior authorization is required.
	Oxygen equipment and supplies	$0	Our plan has preferred vendors/manufacturers for durable medical equipment (DME). Contact the CareAdvantage Unit for more information. A referral is required for DME used outside of the home. Prior authorization is required.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued on the next page)	Home health services	$0	Referral is required. Prior authorization is required. Medicare-covered home health visits Eligibility for the following services applies only to CBAS. Beneficiary must be 18 years or older, and meet nursing facility level of care: • additional hours of care • personal care services
	Home services, such as cleaning or housekeeping, or home modifications such as grab bars	$0	Limited benefit restricted to those with specific needs as determined by individualized care plan. In-home Supportive Services (IHSS) are provided through San Mateo County Aging and Adult Services. Call the Aging and Adult Services TIES line at 1-800-675-8437 or Dial 7-1-1 for the California Relay Service TTY. A social worker will call you back to schedule a home visit to determine your eligibility and need for IHSS. Personal care and homemaker services beyond what can be provided through IHSS are accessible through the Community Supports benefits.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
You need help living at home (continued)	Adult day health, Community Based Adult Services (CBAS), or other support services	$0	Prior authorization is required. Eligibility to participate in community-based adult services (CBAS) also formerly known as Adult Day Health Care (ADHC) is determined by an assessment and individualized plan of services that meets your specific health and social needs. CBAS is a managed care benefit, so it is covered by HPSM. Note: If a CBAS facility is not available, HPSM can explore an alternative facility and/or services that will best meet your needs.
	Day habilitation services	$0	
	Services to help you live on your own (home health care services or personal care attendant services)	$0	In-home Supportive Services (IHSS) are provided through San Mateo County Aging and Adult Services. Call the Aging and Adult Services TIES line at 1-800-675-8437 or Dial 7-1-1 for the California Relay Service TTY. A social worker will call you back to schedule a home visit to determine your eligibility and need for IHSS." Personal care and homemaker services beyond what can be provided through IHSS are accessible through the Community Supports benefit.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued on the next page)	Chiropractic services	$0	Limited to the treatment of the spine by manual manipulation and limited to 24 visits. Covers: • Children under age 21 • Adults who receive these services at a hospital outpatient clinic • Pregnant women if the condition might complicate the pregnancy. • Residents in a nursing or intermediate care facility. Read the *Evidence of Coverage (Member Handbook)* Chapter 4 for more information
	Worldwide Emergency Coverage	$0	While you are traveling anywhere in the world, trips for 6 months or less, you will have coverage for emergency care and emergency services up to $25,000.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued)	Healthy Foods/Groceries	$0	We cover some food products through our Healthy Foods program at no cost to you. You will receive an allowance or spending limit per quarter (every 3 months), to purchase food items at retail stores, or through our vendor's website. This benefit becomes available on the first day of each quarter; January 1, April 1, July 1, and October 1. Any remaining balance does not carry over to the next quarter(s). You will lose any unspent balance as of the 1st of the next quarter. You can use this benefit to get items such as fruits, vegetables, meats and can foods, and other eligible products included on the vendor's website, and/or retail stores (based on approved list). • **$65 quarterly allowance** **In order to be eligible for this benefit you must have certain chronic conditions.** **Items must be part of authorized list of approved food products.**

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued)	Over-the-Counter (OTC) Items	$0	We cover some Over the Counter (OTC) products through our OTC+ program at no cost to you. You will receive an allowance or spending limit per quarter (every 3 months), to purchase OTC items and supplies at retail stores, through the OTC mail-order catalog, or our vendor's website. This benefit becomes available on the first day of each quarter; January 1, April 1, July 1, and October 1. Any remaining balance does not carry over to the next quarter(s). You will lose any unspent balance as of the 1st of the next quarter. You can use this benefit to get items such as acetaminophen, bandages, cold and cough medicines, and other eligible products included in the mail-order catalog, vendor's website, and/or retail stores (based on approved list by CMS). • **$90 quarterly allowance** Items must be part of CMS authorized list of approved OTC products.

Health need or concern	Services you may need	Your costs for in-network providers	Limitations, exceptions, & benefit information (rules about benefits)
Additional services (continued)	Diabetes supplies and services	$0	Prior authorization is required if supplies are non-formulary. Includes: • Diabetes monitoring supplies and • Therapeutic shoes or inserts Our plan limits Diabetic Supplies and Services to specific manufacturers. Contact the plan for more information.
	Prosthetic services	$0	
	Radiation therapy	$0	Prior authorization maybe required depending on the type of service/procedure.
	Services to help manage your disease	$0	Includes diabetes self-management training.

The above summary of benefits is provided for informational purposes only and is not a complete list of benefits. For a complete list and more information about your benefits, you can read the CareAdvantage *Evidence of Coverage (Member Handbook)*. If you don't have an Evidence of Coverage (*Member Handbook)*, call the CareAdvantage Unit at the numbers listed at the bottom of this page to get one. If you have questions, you can also call the CareAdvantage Unit or visit www.hpsm.org/careadvantage.

D. Benefits covered outside of CareAdvantage

There are some services that you can get that are not covered by CareAdvantage but are covered by Medicare, Medi-Cal, or a State or county agency. This is not a complete list. Call the CareAdvantage Unit at the numbers listed at the bottom of this page to find out about these services.

Other services covered by Medicare, Medi-Cal, or a State Agency	Your costs
Medi-Cal Dental Fee-for-Service [*all counties except Sacramento and San Mateo, and some members in Los Angeles county*] contact Medi-Cal Dental at 1-800-322-6384 or visit the website at smilecalifornia.org/. Dental services in San Mateo covered through the Health Plan of San Mateo (HPSM) HPSM Medi-Cal Members, www.hpsm.org/dental, 1-800-750-4776 or 1-650-616-2133. TTY: 1-800-735-2929 or dial 7-1-1.	$0
Certain hospice care services covered outside of CareAdvantage	$0
Psychosocial rehabilitation	$0
Targeted case management	$0
Rest home room and board	$0
Medi-Cal Rx covered drugs	$0
In-Home Support Services (IHSS)	$0
Specialty mental health and substance use disorder services	$0
Assisted living waiver (ALW)	$0
Multipurpose senior services program (MSSP)	$0
Regional center services	$0

E. Services that CareAdvantage, Medicare, and Medi-Cal do not cover

This is not a complete list. Call the CareAdvantage Unit at the numbers listed at the bottom of this page to find out about other excluded services.

Services CareAdvantage, Medicare, and Medi-Cal do not cover	
Full-time nursing care in your home	This plan does not cover full-time nursing care in your home.
Radial keratotomy, LASIK surgery, vision therapy, and other low-vision	This plan does not cover radial keratotomy, LASIK surgery, vision
Naturopath services (the use of natural or alternative treatments)	This plan does not cover naturopath services.

F. Your rights as a member of the plan

As a member of CareAdvantage, you have certain rights. You can exercise these rights without being punished. You can also use these rights without losing your health care services. We will tell you about your rights at least once a year. For more information on your rights, please read the *Evidence of Coverage (Member Handbook)*. Your rights include, but are not limited to, the following:

- **You have a right to respect, fairness, and dignity.** This includes the right to:
  - Get covered services without concern about medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity) sexual orientation, national origin, race, color, religion, creed, or public assistance
  - Get information in other languages and formats (for example, large print, braille, or audio) free of charge
  - Be free from any form of physical restraint or seclusion
- **You have the right to get information about your health care.** This includes information on treatment and your treatment options. This information should be in a language and format you can understand. This includes the right to get information on:
  - Description of the services we cover
  - How to get services
  - How much services will cost you
  - Names of health care providers

- **You have the right to make decisions about your care, including refusing treatment.** This includes the right to:
  - Choose a primary care provider (PCP) and change your PCP at any time during the year
  - Use a women's health care provider without a referral
  - Get your covered services and drugs quickly
  - Know about all treatment options, no matter what they cost or whether they are covered
  - Refuse treatment, even if your health care provider advises against it
  - Stop taking medicine, even if your health care provider advises against it
  - Ask for a second opinion. CareAdvantage will pay for the cost of your second opinion visit
  - Make your health care wishes known in an advance directive
- **You have the right to timely access to care that does not have any communication or physical access barriers.** This includes the right to:
  - Get timely medical care
  - Get in and out of a health care provider's office. This means barrier-free access for people with disabilities, in accordance with the Americans with Disabilities Act
  - Have interpreters to help with communication with your health care providers and your health plan
- **You have the right to seek emergency and urgent care when you need it.** This means you have the right to:
  - Get emergency services without prior authorization in an emergency
  - Use an out-of-network urgent or emergency care provider, when necessary
- **You have a right to confidentiality and privacy.** This includes the right to:
  - Ask for and get a copy of your medical records in a way that you can understand and to ask for your records to be changed or corrected
  - Have your personal health information kept private
- **You have the right to file a complaint or appeal a denied, delayed, or modified service, please see section G below.** This includes the right to:

- File a complaint or grievance against us or our providers
- Appeal certain decisions made by us or our providers
- File a complaint with the California Department of Managed Health Care (DMHC) through a toll-free phone number (1-888-466-2219), or a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC website (www.dmhc.ca.gov/) has complaint forms, Independent Medical Review (IMR) application forms, and instructions available online.
- Ask DMHC for an IMR of Medi-Cal services or items that are medical in nature
- Ask for a State Hearing
- Get a detailed reason for why services were denied and ask for free copies of all the information used to make the decision

For more information about your rights, you can read the *Evidence of Coverage (Member Handbook)*. If you have questions, you can call CareAdvantage the CareAdvantage Unit at the numbers listed at the bottom of this page.

You can also call the special Ombudsman for people who have Medicare and Medi-Cal at 1-855-501-3077, Monday through Friday, between 9:00 a.m. and 5:00 p.m., or the Medi-Cal Office of the Ombudsman1-888-452-8609, Monday through Friday, between 8:00 a.m. and 5:00 p.m.

G. How to file a complaint or appeal a denied, delayed, or modified service

If you have a complaint or think CareAdvantage improperly denied, delayed, or modified a service, call the CareAdvantage Unit at the numbers listed at the bottom of this page. You may be able to appeal our decision.

For questions about complaints and appeals, you can read Chapter 9 of the *Evidence of Coverage (Member Handbook)*. You can also call the CareAdvantage Unit at the numbers listed at the bottom of this page.

For complaints, grievances, and appeals, you can reach us by:

Phone: 1-866-880-0606, TTY 1-800-735-2929 or dial 7-1-1

Fax: 1-650-616-2190

Online: grievance.hpsm.org

Mail: Grievance and Appeals Unit
Health Plan of San Mateo
801 Gateway Blvd., Suite 100
South San Francisco, CA 94080

If you disagree with a decision made by the HPSM about your coverage, or feel unsatisfied with the process for resolving your complaint, you can file a complaint with or ask for Independent Medical Review (IMR) from the Help Center at the California Department of Managed Health Care (DMHC). You can contact the Department of Managed Health Care's Independent Medical Review (IMR) by:

Phone: 1-888-466-2219, TDD 1-877-688-9891

Fax: 1-916-255-5241

Online: https://www.dmhc.ca.gov/FileaComplaint.aspx

Mail: Help Center
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814

By filing a complaint, the DMHC will review our decision and make a determination. An IMR is available for any Medi-Cal covered service or item that is medical in nature. An IMR is a review of your case by doctors who are not part of our plan or a part of the DMHC. If the IMR is decided in your favor, we must give you the service or item you requested. You pay no costs for an IMR.

You can file a complaint or apply for an IMR if our plan:

- Denies, changes, or delays a Medi-Cal service or treatment because our plan determines it is not medically necessary.
- Will not cover an experimental or investigational Medi-Cal treatment for a serious medical condition.
- Will not pay for emergency or urgent Medi-Cal services that you already received.
- Has not resolved your Level 1 Appeal on a Medi-Cal service within 30 calendar days for a standard appeal or 72 hours for a fast appeal.
- Disputes whether a surgical service or procedure was cosmetic or reconstructive in nature.

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. You can read Chapter 9 of the *Evidence of Coverage* (*Member Handbook)* 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.

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 using a doctor who is not in your health plan's network, it is important that you get and send us your medical records from that doctor. Your health plan is required to get copies of your medical records from doctors who are in the network.

If the DMHC decides that your case is not eligible for IMR, the DMHC will review your case through its regular consumer complaint process. Your complaint should be resolved within 30 calendar days of the submission of the completed application. If your complaint is urgent, it will be resolved sooner.

H. What to do if you suspect fraud

Most health care professionals and organizations that provide services are honest. Unfortunately, there may be some who are dishonest.

If you think a doctor, hospital or other pharmacy is doing something wrong, please contact us.

- Call us at the CareAdvantage Unit. Phone numbers are the numbers listed at the bottom of this page.
- Or, call the Medi-Cal Customer Service Center at 1-800-541-5555. TTY users may call 1-800-430-7077.
- Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users may call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

If you have general questions or questions about our plan, services, service area, billing, or Member ID Cards, please call the CareAdvantage Unit:

1-866-880-0606
Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m.
The CareAdvantage Unit also has free language interpreter services available for non-English speakers.

TTY 1-800-735-2929 or dial 7-1-1
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m.

If you have questions about your health:

- Call your primary care provider (PCP). Follow your PCP's instructions for getting care when the office is closed.
- If your PCP's office is closed, you can also call Nurse Advice Line (NAL). A nurse will listen to your problem and tell you how to get care. (Example: urgent care, emergency room). The numbers for the Nurse Advice Line (NAL) are:

1-833-846-8773
Calls to this number are free. 24 hours a day, 7 days a week
CareAdvantage also has free language interpreter services available for non-English speakers.

1-800-735-2929 or dial 7-1-1
Calls to this number are free. 24 hours a day, 7 days a week

If you need immediate behavioral health care, please call the Behavioral Health and Recovery Services Access Call Center:

1-800-686-0101
Calls to this number are free. 24 hours a day, 7 days a week
CareAdvantage also has free language interpreter services available for non-English speakers.

1-866-880-0606
Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m.


San Mateo County
El Condado de San Mateo
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San Francisco
SFO
San Bruno
Pacifica
Millbrae
Burlingame
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Hillsborough
Foster City
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HealthPlan OF SAN MATEO
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ACCREDITED NCQA HEALTH PLAN ACCREDITED
★★★★☆

801 Gateway Boulevard, Suite 100
South San Francisco, CA 94080

tel 866.880.0606 toll-free
tel 650.616.0050 local
fax 650.616.0060
tty 800.735.2929 or dial 7-1-1

www.hpsm.org/careadvantage

Call Center Hours:
Monday through Sunday
8:00 a.m. to 8:00 p.m.